MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04733 04727

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MILDRED	A	ATHEY	4 30 69	1:15PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	10-22-86	82 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
PENNYLVANIA	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Housekeeper	At Home

13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE	13b. COUNTY	CITY OR TOWN	13c. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
~~PENNA~~ MARYLAND	~~ALLEGANY~~	~~BEDFORD~~ CUMBERLAND Rt 3	NO ☒	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN		SANDERS	EMILY		WALTERS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	217-05-3177 D	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive heartfailure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heartdisease — yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Pneumonia.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 4/20, 19 69, to 4/30, 19 69, that (I) (we) last saw the deceased alive on 4/30 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
G. Simons	MD				5/4/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. G. SIMONS	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/3/69	Zion Memorial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	MAY 5 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04734 04728

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)	First: MABEL	Middle: M.	Last: BAER	2a. DATE OF DEATH: Month APRIL	Day 27	Year 69	2b. HOUR: 11:00 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 9-7-1900	6. AGE (In years last birthday): 68 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): MYERSDALE, PA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.				
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): TEACHER	12b. KIND OF BUSINESS OR INDUSTRY: EDUCATION				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: PENNA.	13b. COUNTY	13c. CITY OR TOWN: MYERSDALE	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 122 BROADWAY			
14. FATHER'S NAME First: C.	Middle: P.	Last: BAER	15. MOTHER'S MAIDEN NAME First: MAGGIE	Middle	Last: LIEBERKNIGHT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	16b. SOCIAL SECURITY NO. (If yes give war or dates of service): 187-36-7988	17. INFORMANT: PTS. HOSP. CHART	Address: SACRED HEART HOSPITAL 900 SETON DRIVE CUMBERLAND, MD. 21502				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CARDIAC ARREST

DUE TO, OR AS A CONSEQUENCE OF

(b): CEREBRAL ATROPHY AND EDEMA

DUE TO, OR AS A CONSEQUENCE OF

(c):

3471

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): DIABETES MELLITUS

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
4-22-69	ABDOMINAL ADHESIONS	YES ☒ NO ☐	YES

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

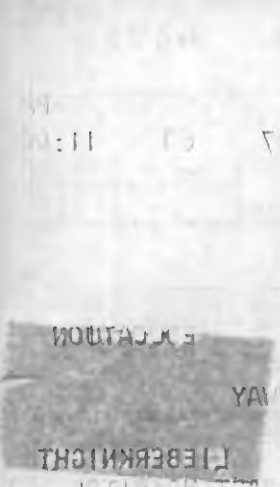
22a. **I certify** thot (I) (this hospitol) ottended the deceased from _____, 19____, to _____, 19____, thot (I) (we) lost sow the deceased olive on _____ 19____, ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stated above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
M. McKeen Kaufman	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	4-28-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
MATTHEW KAUFMAN, M.D.	912 SETON DRIVE CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/30/1969	Union Cemetery	Meyersdale SomersetPa

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Merle Ray Leckimby	Price Funeral Home 325 MainSt Meyersdale, Pa.	DATE MAY 2 1969	Charles Judge



1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04735 04729

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First	Middle	Last
Toleda	Mae	Bennett

2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month Day Year: April 10, 1969 — 2b. HOUR: 9:45 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	6/14/1892	76 YRS.		

2c. DATE PRONOUNCED DEAD Month Day Year: April 10, 1969 — 2d. HOUR: 9:45 P M

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9. COUNTY OF DEATH
Penna	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital--DOA	Housekeeper	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Flintstone	YES [ ] NO [X]	

99 01 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Michael		Northcraft	Leona		Wilson

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
No	217-10-6634D	Alvin H. Bennett	26767 Wiley Ford, W. Va

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — Approximate interval between onset and death: Sudden

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — -----

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES [ ] NO [XX]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]

22b. DATE SIGNED: April 10, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/13/69	Mt Zion Cemetery	Chaneysville Bedford Penna

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	APR 15 1969	[signature]

VR A15ME (5)
10M REV 1/68

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04736 04736

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
BABY	GIRL	BLACKER	APRIL	15	1969	11:45 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	4-15-69	YRS.		1 / 48

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MD.	USA	NEVER MARRIED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	none	none

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	10 HARRISON ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GARY	L.	BLACKER	JUDY	M.	HERSH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	none	MEMORIAL HOSP.	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Failure of All Systems
DUE TO, OR AS A CONSEQUENCE OF (b) Previable Immaturity
DUE TO, OR AS A CONSEQUENCE OF (c)
777X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Leland B. Ranson		[X]	[ ]	[ ]	18 April 69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
LELAND B. RANSOM, M.D.	401 DECATUR ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Apr. 18, 1969	Davis Memorial Cem.	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	APR 21 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper between pages 2 and 3 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(1)
45M - IV 69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04737

CERTIFICATE OF DEATH

04731

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JOHN	R	BRINHAM	APRIL 14 1969	1:40 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	12-10-1895	73 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
GLENCOE, PA.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	DENTIST	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [ ] NO [X]	RT.#3, BOX 38A, BEDFORD RD.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
MILLARD	F	BRINHAM	MALINDA		WILMATH

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
Yes	WWI	215-44-9048	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignant Mixed Cell Tumor Cervical — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO, OR AS A CONSEQUENCE OF (b) Ca Cervix
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 199.1
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
	Cervical nodes-enlgmt.	YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from _____, 19 68, to Apr. 14, 19 69, that (I) (~~we~~) last saw the deceased alive on Apr 13 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Carlton Brinsfield		[X]	[ ]	[ ]	4-15-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. CARLTON BRINSFIELD	401 DECATUR ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/16/69	Sunset Mem Park Mausoleum	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	APR 18 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

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VR A15 (R)
45M - 7-68

04737

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

04738

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04732

1 DECEASED NAME (Type or Print)	First: FRANCIS	Middle: E.	Last: BRODE					2a DATE OF DEATH KNOWN ☒ ESTIMATED ☐	Month: 4	Day: 16	Year: 69	2b. HOUR: 7:50 AM
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: DEC. 15, 1912	6 AGE (In years last birthday): 56 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.			2c DATE PRONOUNCED DEAD	Month: April	Day: 16,	Year: 1969	2d HOUR: 7:50 AM
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: ALLEGANY Md.									
10. CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): ELEC. TRUCK OPERATOR	12b KIND OF BUSINESS OR INDUSTRY: CELANESE									
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: GARRETT	13c. CITY OR TOWN: FROSTBURG	13d INSIDE CITY LIMITS? YES ☐ NO ☒	13e STREET AND NUMBER: ROUTE 2								
14 FATHER'S NAME First: ADAM	Middle	Last: BRODE	15 MOTHER'S MAIDEN NAME First: CLARA	Middle	Last: MICHAELS							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): WW 2	16b SOCIAL SECURITY NO: 214-07-3995	17 INFORMANT: MRS. ANNA M. BRODE, RT. 2, BOX 463, FROSTBURG	ADDRESS									

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Cerebral Edema, Marked — APPROX. INTERVAL BETWEEN ONSET AND DEATH: 38 Hours

DUE TO, OR AS A CONSEQUENCE OF

(b): Contusions of Brain — 32 Hours

DUE TO, OR AS A CONSEQUENCE OF

(c): (Struck by auto)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 814.1

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR AM/PM: 11:15 April 14, 69	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18): Pedestrian struck by Auto
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Rt.#220 at Celenese	21f LOCATION Street or R.F.D. No / City or Town / County / State: Cumberland, Allegany, Maryland

22a. I certify that I took charge of the remains described above, held on Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelis M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: April 16, 1969

ADDRESS (Street, city, town, or county): RD 9, CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	APR. 18, 1969	BRODE CEMETERY	FROSTBURG, MD.

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
J. R. DURST,	FROSTBURG, MD. 21532	APR 22 1969	Charles Yonge

VR A15ME (5) 10M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

04739

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04733

1. DECEASED-NAME (Type or print) First: (JOHN)	Middle: W.H.	Last: BUCHANAN	2a. DATE OF DEATH: Month 4 Day 8 Year 69	2b. HOUR: 11:15 P.M.	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 2-[illegible]-02	6. AGE (In years last birthday): 67 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): PRESIDENT	12b. KIND OF BUSINESS OR INDUSTRY: BUCHANAN LUMBER		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: W. VA.	13b. COUNTY: MINERAL	13c. CITY OR TOWN: KEYSER	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Carskadon Lane	
14. FATHER'S NAME First: HOWARD	Middle:	Last: BUCHANAN	15. MOTHER'S MAIDEN NAME First: (RHODES) ELIZABETH	Middle:	Last: BUCHANAN
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 171-07-2202	17. INFORMANT: HOSPITAL RECORDS	Address: 900 SETON DR. CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CEREBRO-VASCULAR ACCIDENT (THROMBOSIS) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 DAYS

DUE TO, OR AS A CONSEQUENCE OF (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 4-14-59, to 4-8-69, that (I) (we) last saw the deceased alive on 4-8-1669, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ralph Brown M.D. DEGREE	ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED: 4-9-69	
22d. PHYSICIAN'S NAME (Type): R. W. BALLIN, MD.	22e. ADDRESS: 62 GREENE ST., CUMBERLAND, MD.		

23a. BURIAL CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/11/69	23c. NAME OF CEMETERY OR CREMATORY: RoseHill Mausoleum	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR: SILCOX-MERRITT FUNERAL SERV.	ADDRESS: 404 DECATUR CUMBERLAND, MD	25a. RECD BY REGISTRAR DATE: APR 14 1969	25b. REGISTRAR'S SIGNATURE: [illegible]	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04740 04734

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
WALTER	W.	BURKETT	4 29 69	5:45A

3. SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / M.N
MALE	WHITE	7-15-1909	59 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PA.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Supervisor Laborer	

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
PA.	Bedford	HYNDMAN	YES [X] NO [ ]	MILL ST.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
SIMON		BURKETT	BERTHA		GARDNER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
	208-03-2187	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY-
IMMEDIATE CAUSE (a) Esophageal Varicael Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 24 hrs
DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis, Nutritional — 10 years
DUE TO, OR AS A CONSEQUENCE OF (c)
5719
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Multiple Hepatomas

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19___, to 4-29-69, 19 69, that (I) (we) last saw the deceased alive on 4-29-69 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
[signature]	ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ]	

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
DR. MILTENBERGER	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	May 2, 1969	Mader Cemetery	Cash's Mills, Pa. RD#1

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Harvey A. Feigley	Mills, Pa. 15	MAY 5 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (2)
45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04741 — 04735

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day	2b HOUR
WILLIAM	J.	COLEMAN	APRIL 3 1969	3:55A

3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	6-8-07	61 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Retired Mechanic	Automobile

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	601 OLDTOWN RD.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH		COLEMAN	ANNA		DECKER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
X		214-05-6272	MEMORIAL HOSP., CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Uremia, due do Lower Nephr on Neph rosis

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Anemia due to Hypoprotenemia, due to Rheumatoid Arthritis; Toxic Hepatitis, with

DUE TO, OR AS A CONSEQUENCE OF (c) Cirrhosis of Liver; Anascara, with Refractory Heart Failure; Ulcerative Colitis

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Steroid Therapy—Esophageal Varices, Chronic Gastritis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from Sept. 1958 to April 1969, that (I) (we) last saw the deceased alive on 4/2 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS [ ]	22c. DATE SIGNED
					4/7/69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
G.O. HIMMELWRIGHT, M.D.	133 VIRGINIA AVE., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Apr. 7, 1969	St. Mary's Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	APR 8 1969	Marian Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04742 04736

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First: CLAIR Middle: Ernest Last: COOPER		2a. DATE OF DEATH Month: APRIL Day: 20 Year: 1969	2b. HOUR 9:00PM
3 SEX: MALE	4 RACE: White	5 DATE OF BIRTH: 5-15-04	6 AGE (in years last birthday): 64 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.
7a BIRTHPLACE (State or foreign country): W.VA.	7b CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street and No.): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): MANAGER	12b KIND OF BUSINESS OR INDUSTRY: LEWIS THEATRE
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W.VA.	13b COUNTY: Greenbrier	13c CITY OR TOWN: LEWISBURG	13d INSIDE CITY LIMITS? YES [X] NO [ ]
13e STREET AND NUMBER: 106 NORTH COURT ST			
14 FATHER'S NAME First: GORDON Middle: LEE Last: COOPER		15 MOTHER'S MAIDEN NAME First: NANCY Middle: E. Last: MEADOWS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No		16b. SOCIAL SECURITY NO.: 033-12-3950	17 INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.
IMMEDIATE CAUSE (a) Coronary thrombosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) Hypernephroma left kidney with
DUE TO, OR AS A CONSEQUENCE OF (c) Extension to adjacent tissues and
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a). Metastases to lymph nodes - lung (left) & brain

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 4-11, 19 69 to 4-20, 19 69, that (I) (we) last saw the deceased alive on 4-20 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: W. F. Williams DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]
22c DATE SIGNED: 4-21-69

22d. PHYSICIAN'S NAME (Type): DR. W.F.WILLIAMS
22e ADDRESS: CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: April 23, 1969	23c NAME OF CEMETERY OR CREMATORY: Hilltop Cemetery	23d LOCATION (City or Town): Hinton	(County): Summers (State): W. Va.
24. FUNERAL DIRECTOR ADDRESS: H. Wayne George, Cumberland, Md.		25a REC'D BY REGISTRAR DATE: APR 23 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04743 04737

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MARGARET	L.	COWAN	4	18	69	9:07 A.M.

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	1-6-1924	45 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
W. VA.	U. S. A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Clerk	Ballistics Lab

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	106 WILLS CREEK AVE.,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WILLIAM	M.	HULL	ANNA	C.	SHUMAN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	Address
no				MEMORIAL HOSPITAL-CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 mos

DUE TO, OR AS A CONSEQUENCE OF

(b) Adenocarcinoma of colon — 2 years

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
Sept 68	Colon obstruction	YES [ ] NO [X]	Yes

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
[ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M. Month Day Year 19	

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 2 Dec 68, 19 69, to 18 Apr, 19 69, that (I) (we) last saw the deceased alive on 18 Apr 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
		[X]	[ ]	[ ]	20 Apr 69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
DR. F. W. MILTENBERGER	122 S. CENTRE ST., CUMBERLAND, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Apr.21,1969	Sunset Memorial Park	Cumberland, Allegany, Md.

24 FUNERAL DIRECTOR ADDRESS	25a. FILED BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	APR 22 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-trans't permit. Then please remove carbon papers (Pages 3 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4
45M - 1-69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, with 72 hours after death.

VR A15-M 45M

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04744 04738

1. DECEASED NAME (Type or print) First: WALTER	Middle: A.	Last: CROWE	2a. DATE OF DEATH: APRIL Month 21 Day 1969 Year
2b HOUR: 9:14 M			
3 SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: JUNE 6, 1889	6 AGE (In years last birthday): 79 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md
10 CITY OR TOWN OF DEATH: FROSTBURG	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MINERS HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): BRICK WHEELER	12b KIND OF BUSINESS OR INDUSTRY: BRICK COMPANY
13a USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: MT. SAVAGE	13d INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER:			
14 FATHER'S NAME First: JOSEPH	Middle: A.	Last: CROWE	15. MOTHER'S MAIDEN NAME First: VIRGINIA Middle:	Last: KIRBY
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown:	(If yes give war or dates of service):	16b SOCIAL SECURITY NO: 214-01-0129	17 INFORMANT: LOUIS CROWE, FROSTBURG, MD. 21532 Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Uremia — Anuria — — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs 22-

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 52X

DUE TO, OR AS A CONSEQUENCE OF (b): Chronic Glomerulonephritis — 8 yrs 2-

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Severe Anemia

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from 3-7, 1969, to 4-21, 1969, that (I) (we) last saw the deceased alive on 4-21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE: Martin Rothstein DEGREE	ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c DATE SIGNED: 4-22-69	
22d. PHYSICIAN'S NAME (Type): MARTIN ROTHSTEIN, MD. D.	22e ADDRESS: 48 BROADWAY, FROSTBURG, MD. 21532		

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b DATE: 4-23-69	23c NAME OF CEMETERY OR CREMATORY: METHODIST CEMETERY	23d LOCATION (City or Town): MT. SAVAGE, MD.	(County) (State)
24 FUNERAL DIRECTOR: JOSEPH R. DURST, FROSTBURG, MD. 21532	ADDRESS	25a. RECD BY REGISTRAR DATE: APR 24 1969	25b REGISTRAR'S SIGNATURE: Edmund Judge	

1

04745

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04739

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the informant, funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be detached for use as the burial-transit permit. Page 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: JAMES	Middle: L.	Last: DAVIS	2a. DATE OF DEATH Month: 4 Day: 28 Year: 69	2b. HOUR: 8:45 AM
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 12-20-03	6. AGE (In years last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED MAINTENANCE	12b. KIND OF BUSINESS OR INDUSTRY: R.R.		
13a. USUAL RESIDENCE (Where deceased lived if institution. Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 167 E. MAIN ST.	
14. FATHER'S NAME First: JOHN	Middle: R.	Last: DAVIS	15. MOTHER'S MAIDEN NAME First: MARY	Middle: A.	Last: HOUSE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Acute myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hr

DUE TO OR AS A CONSEQUENCE OF

(b): severe arteriosclerotic heart disease.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, not by medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 7/22/67, to 4/28/67, that (I) (we) last saw the deceased alive on 4/27/67, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W Himmler — DEGREE: ATTENDING PHYS. [X] MED DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 5-3-69

22d. PHYSICIAN'S NAME (Type): DR. W. A. HIMMLER — 22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 5-1-69	23c. NAME OF CEMETERY OR CREMATORY: FBG. MEMORIAL PARK	23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.	
24. FUNERAL DIRECTOR: JOSEPH R. DURST, SR.,	ADDRESS: FROSTBURG, MD. 21532	25a. RECD BY REGISTRAR DATE: MAY 5 1969	25b. REGISTRAR'S SIGNATURE: Charles Yonge	

VR A15 45M - 1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04746 — 04710

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
LESLIE	HOLMES	DEMPSAY	APRIL 11 1969	11:25P

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
MALE	WHITE	11-1-12	56 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARR / WIDOWED / DIVORCED	9. COUNTY OF DEATH
NEBRASKA	USA	DIVORCED [X]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSP.	Electrician	Cetanese

13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [ ] NO [X]	ROUTE #5 Bowling Green

14 FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or Unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT Address
ALEXANDER W. DEMPSAY	SARAH MARGARET SEARS	No.	481-09-0408	MEMORIAL HOSP., CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pneumonatosis	6 wks
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Carcinoma of R. Lung	6 mos
DUE TO, OR AS A CONSEQUENCE OF (c)	Secondary Anaemia	6 wks

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M P.M Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Mar 1, 19 69 to Apr 11, 19 69, that (I) (we) last saw the deceased alive on Apr 11, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED
Clay E. Durrett		[X]	[ ]	[ ]	4/17/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. CLAY DURRETT	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4/17/69	Graceland Park Cemetery	Sioux City, Woodbury, Iowa

24. FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Wayne George 202 Greene St. Cumberland, Md.	APR 15 1969	Charles Judge

VR A15 (4)
45M - 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04747 04741

1 DECEASED-NAME (Type or Print) First: Elwood	Middle: Weldon	Last: Dorsey	2a DATE KNOWN OF DEATH ESTIMATED ☒ Month Day Year: April 12, 1969	2b HOUR: 8:05 P M			
3 SEX: Male	4 RACE: Colored	5 DATE OF BIRTH: 12/15/99	6. AGE (In years last birthday): 69 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month April 12, Day 1969 Year 19	2d HOUR: 8:05PM
7a BIRTHPLACE (State or foreign country): Cumberland	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland Md.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital--DOA	12a USUAL OCCUPATION (Kind of work done during most of work life, even if retired): Retired Laborer	12b KIND OF BUSINESS OR INDUSTRY: Construtione				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 622 Bedford St. Cumb. Md.			
14 FATHER'S NAME First: John	Middle	Last: Dorsey	15 MOTHER'S MAIDEN NAME First: Anna	Middle	Last: Taxer		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT: Memorial Records	ADDRESS: Cumberland Md.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART I DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P M 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R F D No.	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: April 12, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/16/69	SS. Peter & Paul Cem.	Cumberland Md. (Allegany)

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Louis Stein Inc. Cumberland Md.	APR 16 1969	Charles Judge

VR A15ME (5) 10M REV 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 15
10M REV 1/68

04748

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04742

1. DECEASED NAME (Type or Print)	First	Middle	Last
	Dorothy	June	Elliott

2a. DATE KNOWN OF DEATH ESTIMATED ☒ Month Day Year: April 30, '69 — 2b. HOUR: 1:54 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	White	June 17,1922	46 YRS.		

2c. DATE PRONOUNCED DEAD: Month APRIL Day 30, Year 1969 — 2d. HOUR: 11:54 AM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	MEMORIAL HOSPITAL--DOA	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☒ NO ☐	353 Dorn Ave.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Walter	H.	Simpson	Bella L.	Brown	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
no		Mr. Joseph W. Elliott, Cumberland Md.	Husband

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) ASPHYXIATION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINUTES

DUE TO, OR AS A CONSEQUENCE OF

(b) STATUS EPILEPTICUS — ----

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2452

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: April 30, 1969

ADDRESS (Street, city, town, or county)

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	May 3,1969	Frostburg Memorial Park	Frostburg, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	MAY 6 1969	Charles Lodge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04749 04743

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WOODROW	S	ELLIOTT	APRIL 27, 1969	11:22 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
MALE	WHITE	8-31-1918	50 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNA	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Boilermaker- B & O R.R.	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	1100 BEDFORD ST.,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
SHANNON		ELLIOTT	MAUDE	M.	ZEMBOWER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
Yes	WW II	174-16-8676	MEMORIAL HOSPITAL,	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Carcinoma of Esophagus with Metastases	Several years
DUE TO, OR AS A CONSEQUENCE OF (b)		
DUE TO, OR AS A CONSEQUENCE OF (c)		

150X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 1967, 19___, to April 24, 1969, that (I) (we) last saw the deceased alive on April 25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS [ ]	22c. DATE SIGNED
Calvin Y. Hadidian					4/30/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. CALVIN HADIDIAN	203 GREENE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/30/69	Sunset Memorial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Silcox- Merritt Funeral Service.	Cumberland, MD 21502	MAY 2 1969	Clarence Yonge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1 [illegible] 45M - [illegible] 69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04750 04744

1 DECEASED-NAME (Type or Print) First: Florence; Middle: [illegible]; Last: [illegible]						2a. DATE OF DEATH (KNOWN) (ESTIMATED) Month: April Day: 18 Year: 19[illegible]	2b. HOUR [illegible] AM PM
3 SEX: [illegible]	4. RACE: White	5 DATE OF BIRTH: [illegible].21.19[illegible]	6 AGE (In years last birthday): 49 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / M.N.	2c. DATE PRONOUNCED DEAD Month: April Day: 18 Year: 19[illegible]	2d. HOUR 3 PM
7a BIRTHPLACE (State or foreign country): [illegible]	7b CITIZEN OF WHAT COUNTRY? U.S.	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Alle[illegible]y Md.				
10 CITY OR TOWN OF DEATH: Cu[illegible]berland, Md.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 21[illegible] Decatur Street	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): [illegible]	12b KIND OF BUSINESS OR INDUSTRY				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: [illegible]	13b. COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 214 Decatur St.			
14. FATHER'S NAME First Middle Last: Henry E. Lowery			15. MOTHER'S MAIDEN NAME First Middle Last: Emma Devore Lowery				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 219-46-2301	17. INFORMANT: Mrs. Paulette McCoy	ADDRESS: [illegible]-45 [illegible], Md.				

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Thrombosis — 11

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Sclerosis — -----

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: April 18, 196[illegible]

ADDRESS (Street, city, town, or county): [illegible]berland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County)
Burial	April 21, 1969	Rest Lawn [illegible]	[illegible]V[illegible] 21502

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
[illegible]	[illegible]	APR 22 1969	[illegible]

VR A15ME (5) 10M REV. 1/68

1

FOR STATE HEALTH DEPT.

Item5 Film Ch12
5/15/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
04751 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04745

1. DECEASED-NAME (Type or Print) First: HEZEKIAH	Middle:	Last: FAGAN	2a DATE KNOWN OF DEATH ESTIMATED ☒ Month Day Year: April 16 69	2b HOUR: 7:15 P M							
3 SEX: MALE	4 RACE: COLORED	5. DATE OF BIRTH: Jan. 22, 1902 / FEB. / / 1902	6 AGE (In years last birthday): 67 YRS	IF UNDER 1 YEAR MONTHS:	DAYS:	IF UNDER 24 HRS HOURS:	MIN:	2c. DATE PRONOUNCED DEAD Month: APRIL Day: 16 Year: 69	2d HOUR: 7:15 P M		
7a BIRTHPLACE (State or foreign country): CUMBERLAND	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☒ NEVER MARRIED ☐ W.DOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: ALLEGANY Md.								
10 CITY OR TOWN OF DEATH: CUMBERLAND MD.	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 104 N. MECHANIC STREET.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): LABORER	12b KIND OF BUSINESS OR INDUSTRY								
13a USUAL RESIDENCE (Where deceased lived, If institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 104 N. MECHANIC ST.							
14. FATHER'S NAME First: PETER	Middle:	Last: FAGAN	15 MOTHER'S MAIDEN NAME First: MARY	Middle:	Last: MEEKINS						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO.	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT: BERNARD FAGAN	ADDRESS: MARTINSBURG W.VA.							

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Cumberland, Maryland

22b DATE SIGNED: APRIL 16 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	4/19/69	ALLEGANY COUNTY CEMETERY	CUMBERLAND ALLEGANY MD.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Louis Stein Inc. Cumberland Md.	APR 22 1969	Elsworth Yeager

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME 3)
10M REV 1/69

11 1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04752 04746

1 DECEASED NAME (Type or Print) First: JOSEPH	Middle: A.	Last: FINN	2a DATE KNOWN OF DEATH ESTIMATED ☒ Month Day Year: April 24, 69	2b HOUR: 8a M	
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: FEB. 19, 1905	6 AGE (In years last birthday): 64 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
2c. DATE PRONOUNCED DEAD Month: April Day: 24, Year: 1969	2d HOUR: 830 a M				
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: FROSTBURG	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 183 W. MECHANIC ST.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): PATROLMAN	12b KIND OF BUSINESS OR INDUSTRY: STATE COLLEGE		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 183 W. MECHANIC ST.	
14. FATHER'S NAME First: ANDREW	Middle	Last: FINN	15 MOTHER'S MAIDEN NAME First: MARY	Middle	Last: HIGGINS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 214-07-5311	17. INFORMANT ADDRESS: MRS. ANGELA FINN, FROSTBURG, MD. 21532			

MEDICAL CERTIFICATE

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic MD

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b DATE SIGNED: April 24, 1969

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: APR. 26, 1969	23c NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY	23d. LOCATION (City or Town) (County) (State): FROSTBURG, MD.	
24 FUNERAL DIRECTOR ADDRESS: JOSEPH R. DURST, FROSTBURG, MD. 21532		25a REC'D BY REGISTRAR DATE: APR 29 1969	25b REGISTRAR'S SIGNATURE: Wanda, Judge	

VR A15ME (5) 10M REV 1/68

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04753

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04747

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, with 172 hours after death.

1. DECEASED-NAME (Type or print)	First: IRENE	Middle:	Last: FLORA	2a. DATE OF DEATH: Month 4 Day 22 Year 69	2b. HOUR: 4:45 A.M.
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 11-14-1904	6. AGE (In years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): NEW JERSEY	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY		Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 824 YALE ST.,	
14. FATHER'S NAME First: EDWARD LOUIS	Middle:	Last: SAGADY	15. MOTHER'S MAIDEN NAME First: ELIZABETH	Middle:	Last: LUNSLO
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-26-9320	17. INFORMANT: MEMORIAL HOSPITAL-CUMBERLAND, MD.	Address		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Hepato Cellular Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ?

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 5718

DUE TO, OR AS A CONSEQUENCE OF (b): due to Portal Cirrhosis

DUE TO, OR AS A CONSEQUENCE OF (c): with Marked Liver Dysfunction

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I **certify** that (I) (this hospital) attended the deceased from 4-7-, 1969, to 4-22-, 1969, that (I) ~~(we)~~ last saw the deceased alive on 4-21-1969 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death

22b. SIGNATURE: Wm. F. Williams DEGREE: ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22c. DATE SIGNED: 4-24-69

22d. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS — 22e. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/25/1969	23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State): Cumberland Alleg Md.	
24. FUNERAL DIRECTOR: Charles E. Hafer	ADDRESS: Charles E. Hafer, 230 Balto Ave. Cumberland Md.	25a. REC'D BY REGISTRAR DATE: APR 28 1969	25b. REGISTRAR'S SIGNATURE: Charles Judy	

VR A15(M)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04754

CERTIFICATE OF DEATH

04748

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
GEORGE	V.	FOSTER	APRIL 21 1969	3:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	MAY 14, 1900	68 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARITAL STATUS	9. COUNTY OF DEATH
INDIANA	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	Conductor	RAILROAD

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	Allegany	RAWLINGS	YES [ ] NO [X]	RAWLINGS HEIGHTS

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
FRANK		FOSTER	URSULA		ARBUCKLE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
YES	705-10-1592	HOSPITAL RECORD- 900 SETON DRIVE, CUMB., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchogenic Carcinoma Left Lung

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2-3 yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from Jan 1, 1968, to April 21, 1969, that (I) (we) last saw the deceased alive on April 21 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	4/24/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
B.M. SCHINDLER, M.D.	43 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/23/69	Sunset Memorial Park	Cumberland Allegany Md.

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
KIGHT FUNERAL HOME, 309 DECATUR ST., CUMB. MD.	APR 23 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 1-68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 1-67
45M - [illegible]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04755 04743

1 DECEASED NAME (Type or print) First: Irene	Middle: E.	Last: Frye	2a. DATE OF DEATH Month: 4 Day: 23 Year: 69 — 2b. HOUR: 1:45 PM
3 SEX: Female	4. RACE: White	5 DATE OF BIRTH: January 3, 1896	6 AGE (In years last birthday): 73 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS: HOURS / MIN
7a BIRTHPLACE (State or foreign country): W. Virginia	7b. CITIZEN OF WHAT COUNTRY?: Allegany	8 MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH: Allegany, Cumberland Md
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): All. C. Infirmary	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b KIND OF BUSINESS OR INDUSTRY: Own Home
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: Cumberland	13d INSIDE CITY LIMITS? YES X / NO	13e STREET AND NUMBER: 223 Arch Street
14. FATHER'S NAME First: Peter Henry	Middle	Last: Mouse	15 MOTHER'S MAIDEN NAME First: Mary	Middle: Ellen	Last: Kerns
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 705-10-857[illegible]	17 INFORMANT: Homer W. Frye	Address: 223 Arch Street	

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a) Acute Cardiac arrest — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Few minutes
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — many years
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis — many years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a).
Diabetes Mellitus. P.V.D. (2) Mid Thigh amputation - Right Leg.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED While at work / Not while at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a **I certify** that (I) (this hospital) attended the deceased from April 7, 19 69, to April 23, 19 69, that (I) (we) last saw the deceased alive on April 22, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE	DEGREE			22c DATE SIGNED
John A. Topper	ATTENDING PHYS ☑	MED DIRECTOR ☐	STAFF PHYS ☑	4-24-69
22d PHYSICIAN'S NAME (Type) John A. Topper	22e ADDRESS 955 Memorial Hospital Cumberland Md.			

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	April 26, 1969	Sunset Memorial Park	Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.	25a. REC'D BY REGISTRAR DATE APR 28 1969	25b REGISTRAR'S SIGNATURE	

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04756 04750

1 DECEASED NAME (Type or Print)	First	Middle	Last	2a DATE KNOWN OF DEATH / ESTIMATED	Month Day Year	2b. HOUR
	KELLEY	MARIE	FRYE	☒ / ☐	April 5,1969	5p M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c DATE PRONOUNCED DEAD Month Day Year	2d. HOUR
Female	White	Jan. 2,1966	3 YRS			April 5, 1969	5p M

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
Maryland	U. S.	☐ / ☒ / ☐ / ☐	Allegany Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital--DOA	None	

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES / NO	13e STREET AND NUMBER
W,Va.	Hampshire	Greenspring	☐ / ☒	Rural

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
Robert	L.	Frye	Vickie	L.	Twigg

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT	ADDRESS
No	None	Robert L. Frye,	Greenspring, W,Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Asphyxiation — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Drowning — N

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES / NO
		☐ / ☒

21a EXTERNAL CAUSE WAS PRIMARY / OR CONTRIBUTING CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
☒ / ☐	about 4 P.M. April 5 1969	Fell in recently excavated water hole

21d INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State
☐ / ☒	Home (yard)		Hampshire Greenspring,	~~Mineral~~ county,	West Virginia

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED April 5, 1969

ADDRESS (Street, city, town, or county) CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	April 8,1969	Forest Glen	Greenspring Hampshire W,Va.

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Earl Shaffer	Romney, W,Va.	APR 8 1969	J Charles Judge

VR A15ME (5)
10M REV 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PHS 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

04757

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04751

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) First	Middle	Last
ELMER	LEROY	GARLITZ

2a. DATE KNOWN OF DEATH ☒ / ESTIMATED ☐: Month, Day, Year: April 13, 1969 — 2b. HOUR: 2:20 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	DEC. 14, 1906	62 YRS		

2c. DATE PRONOUNCED DEAD: Month, Day, Year: April 13, 1969 — 2d. HOUR: 6:20 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
FROSTBURG	MINERS HOSPITAL	CONSTRUCTION - BURTON CONSTRUCTION CO.	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	GARRETT	FROSTBURG	YES ☐ NO ☒	RT. 2

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
NORMAN	C.	GARLITZ	RHODA		ROBINSON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
	220-16-6705	MRS. RHODA GARLITZ,	RT. 2, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))

PART I. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Transection of Cervical Spinal Cord — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 28 Hours.

DUE TO, OR AS A CONSEQUENCE OF

(b) Fracture of Atlas — "

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
	2:00 PM April 12, 1969	Fell down steps

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No / City or Town / County / State
	Home	R#2 Frostburg, Allegany, Maryland

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER XXX

22b. DATE SIGNED: April 13, 1969

ADDRESS (Street, city, town, or co): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	APRIL 16, 1969	BLOCHER CEMETERY	GARRETT COUNTY, MARYLAND

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	APR 17 1969	Charles Judge

VR A15ME (5) 10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04758 04752

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
ALICE	S.	GILBERT	APRIL 17 1969	12:20 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
FEMALE	WHITE	4-24-88	80 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PA.	USA	WIDOWED [X]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	LA VALE	YES [X] NO [ ]	355 National Hwy

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOHN		ENGLE	AMANDA		SWARNER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	None	MEMORIAL HOSP., CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)
PART I. DEATH WAS CAUSED BY:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Acute myocardial infarction c Ventr. F.	3 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic heart disease	10 Years
DUE TO, OR AS A CONSEQUENCE OF (c)	General arteriosclerosis	15 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO [X]	

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 4-16, 1969, to 4-17, 1969, that (I) (we) last saw the deceased alive on 4-16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Vaclav V. Dross MD		[X]	[ ]	[ ]	4-22-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. V. DROSS	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/19/69	Hillcrest Burial Park	Cumberland Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
William G. Kight	Cumberland, Md.	APR 23 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
45M - 1X62

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04759

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04753

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b HOUR
Alice	May	Godwin	April	27,	1969	4:00 P M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Female	White	Sept. 15, 1887	81 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARR ED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH
W. Va.	U. S. A.		Allegany Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland,	Cumberland Nursing Home	Housewife,	Own home

13a USUAL RESIDENCE (Where deceased lived, if institution- Res dence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIM TS?	13e STREET AND NUMBER
Penna.	Bedford	Bedford	YES ☒ NO ☐	127 So. Wood St.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
John	Leslie	Jones	Laura	Adeline	Moss

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT Address
No, (Yes no, or unknown)	None	Mrs. E. Jeanne Fetters 127 So. Wood St. Bedford, Penna.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cardio-pen[illegible] vasculor disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO, OR AS A CONSEQUENCE OF

(b) arteriosclerosis — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (At home, farm, street factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from 3-15-, 1968, to 4-2[illegible], 1969, that (I) (we) last saw the deceased alive on 4-20 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c DATE SIGNED
L Brings	ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐	4-22-69

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
Dr. Lewis Brings	57 Greene St. Cumberland, Md. 21502

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4/24/69	Rose Hill Cemetery,	Cumberland, Allegany Md.

24 FUNERAL DIRECTOR	ADDRESS	25a ACCEPTED BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
H. Wayne George	Cumberland, Maryland	APR 25 1969	[illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV 1/68

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04760

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item13 Film G412 5/19/69 kk

CERTIFICATE OF DEATH

04754

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	19	2b HOUR
JOHN	EWING	GROWDEN	APRIL	19	1969	2:45 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
MALE	WHITE	12-20-84	84 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PA.	USA	WIDOWED X	ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD. Pa.	Bedford	CUMBERLAND	YES / NO X	RT. # 3

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
ELLSWORTH		GROWDEN	MARY	E.	HARDINGER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT Address
NO	219-46-0185	MEMORIAL HOSP., CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mos

4409

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Advanced arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d INJURY OCCURRED While at work / Not while at work	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that (I) (this hospital) attended the deceased from June, 1965, to 4-18, 1969, that (I) (we) last saw the deceased alive on 4-18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS / MED DIRECTOR / STAFF PHYS.	22c DATE SIGNED
William P James, M.D.			4-19-69

22d. PHYSICIAN'S NAME (Type)	22e ADDRESS
WILLIAM P. JAMES, M. D.	441 N. CENTRE ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	APRIL 19, 1969	CEMTENARY CEMETERY	CUMBERLAND, MD.

24 FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
BYRON KIGHT	CUMBERLAND, MD.	APR 23 1969	Wilmer Updike

VR A15 (4)
45M - 1/68

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04761

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04755

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JOHN	W.	HALL SR.	APRIL 27 1969	6:00P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	JUNE 16, 1910	58 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
PENNSYLVANIA	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	QUALITY CONTROL TECH.	CELANESE

13a. USUAL RESIDENCE (Where deceased lived at time of admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CRESAPTOWN	YES [ ] NO [ ]	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
WALTER		HALL	MARY		GORDON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	214-07-4210	HOSPITAL RECORDS-900 SETON DRIVE, CUMB., MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Chronic cardiac failure	10 yrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Angina pectoris	12 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)	Thyrotoxicosis years ago	4

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cardiac hepatic arteriosclerosis, renal failure

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 1/27/69, 19 57, to 4/27/69, 19 69, that (I) (we) last saw the deceased alive on 4/27/69 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Elizabeth Brings M.D.	M.D.	[X]	[ ]	[ ]	4/27/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
ELIZABETH BRINGS, M.D.	55 GREENE ST., CUMBERLAND, MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/30/1969	Sunset Memorial Park	Near Cumberland Alleg Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
HAFER FUNERAL HOME- LA VALE, MD. 21502 John J. Hafer		MAY 1 1969	Charles Judge

VR A 5
45M - 1 69

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

04762 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) First: Thomas	Middle: J.	Last: Jones	2a DATE KNOWN OF DEATH [X] ESTIMATED [ ] Month, Day, Year: 4/11/1969	2b HOUR: M							
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: 2/25/1886	6. AGE (In years last birthday): 83 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month, Day, Year: 4th, 11th, 1969	2d. HOUR: M				
7a. BIRTHPLACE (State or foreign country): MD.	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]	9 COUNTY OF DEATH: Allegany Md								
10. CITY OR TOWN OF DEATH: Nikep	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired	12b KIND OF BUSINESS OR INDUSTRY: Miner								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b COUNTY: Allegany	13c CITY OR TOWN: Nikep	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER							
14. FATHER'S NAME First: EBENEIZER	Middle	Last: JONES	15. MOTHER'S MAIDEN NAME First: Carolyn	Middle: Jones	Last						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Spanish-American	(If yes give war or dates of service)	16b SOCIAL SECURITY NO: 220-10-1053	17 INFORMANT: Melvin J. Jones, (Son)	ADDRESS: Nikep, Md.							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Sclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]
21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from. Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic
CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]
ADDRESS (Street, city, town, or county): Cumberland, Md.
22b. DATE SIGNED: 4/11/1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4/13/1969	Laurel Hill Cemetery	Moscow, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
GEORGE EICHHORN,	Lonaconing, Md.	APR 16 1969	Charles Yonge

VR A15ME (5)
10M REV 1/68

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 4(17 M)
45M 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04763 04757

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR PM
ERNEST	L	KELLER	APRIL 28 1969	9:30

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	2-13-1911	58 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MD.	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	SUPERVISOR	COLUMBIA GAS OF MD.

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [ ] NO [X]	RT. 3, BEDFORD RD.,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ERNEST		KELLER	MARIETTA		TROUT

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
NO	214-05-9172	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Thrombosis	10 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerotic Heart Disease	6 yrs
DUE TO OR AS A CONSEQUENCE OF (c)		

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2 Item 18)

21d. INJURY OCCURRED While [ ] Not while [ ] at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 4/17/69, 19____, to 4/28/69 19____, that (I) (saw) last saw the deceased alive on 4/28/69, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED
[signature]		5/1/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. R. J. WILLIAMS	122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	5/1/1969	Hillcrest Burial Park	Near Cumberland Alleg Md

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr., 230 Balto Ave. Cumberland,	MAY 5 1969	[signature]

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04764

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item5 Film3411 4/14/69 kk

CERTIFICATE OF DEATH

04758

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
ELLA	S	KORNS	4 3 69	11:00AM

3 SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
FEMALE	WHITE	5-8-90 1891	77 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
PENNSYLVANIA	U.S.A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Retired	

13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
PENNA.		HYNDMAN	YES [ ] NO [X]	RT. 1

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
SAMUEL		LEPLEY	IDA		EMERICK

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17 INFORMANT	Address
NO	172-18-0771	MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Cerebral vascular accident

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) atrial fibrillation

DUE TO, OR AS A CONSEQUENCE OF (c) arteriosclerotic & hypertensive heart disease

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

a. days
b. years
c. yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Diabetes Hypertension

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [ ]	

21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from July, 19 68, to April 3, 19 69, that (I) (we) last saw the deceased alive on April 3, 19 69, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
[signature]		[X]	[ ]	[ ]	April 9 1969

22d PHYSICIAN'S NAME (Type)	22e ADDRESS
DR. S. G. WEISMAN	CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	April 6, 1969	Rose Hill Cemetery	Cumberland, Allegany Co., Md.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Harvey H. Zeigler, Hyndman, Pa. 15545	APR 9 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M 1/69

1 04765 Item1 & Item14 Film G411 4/9/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04759

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
CLARA	Belle B.	LAEMMERT	APRIL 4 1969	1A M

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
FEMALE	WHITE	MAY 2, 1886	82 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9 COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
FROSTBURG	40 WASHINGTON ST.	HOUSE WIFE	

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG	YES ☒ NO ☐	40 WASHINGTON STREET

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Luke	WILLIAM Van	ROBERTSON	TILDA		MIDDLETON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT Address
	215-10-4466A	RALPH A. LAEMMERT, FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Rt. Cardiac Failure	24 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	AHCVD -	3+ years.
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M P.M Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	4				

22a. I **certify** that (I) (this hospital) attended the deceased from 11 [illegible], 1966, to 4/4, 1969, that (I) ~~(we)~~ last saw the deceased alive on 4/1 1969 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death

22b SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c DATE SIGNED
John B. Davis		☒	☐	☐	4/4/69

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
JOHN B. DAVIS, M. D.	2 BROADWAY, FROSTBURG, MD.

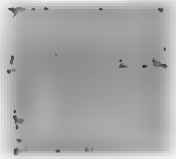
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	4-7-69	FBG. MEMORIAL PARK	FROSTBURG, MD.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
JOSEPH. R. DURST, FROSTBURG, MD. 21532	APR 7 1969	Charles Judy

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M - 1/68



Item13 Film3:12
4/30/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04766 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04766

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death ... any delay is necessary, please execute the certificate, writing the word "pending" in parentheses in Item 18 Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's office along with farm ... 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 DECEASED-NAME (Type or Print) First: [redacted]	Middle: Roy	Last: Edward Leasure	2a DATE KNOWN OF DEATH ESTIMATED ☒ Month Day Year: April 17, 1969	2b HOUR: 6a M		
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: March 11, 1899	6. AGE (In years last birthday): 70 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD Month Day Year: April 17, 1969	2d HOUR: 6a M
7a. BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☐ NEVER MARRIED ☐ W DOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md.				
10. CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Home	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Gardener	12b. KIND OF BUSINESS OR INDUSTRY: Flower				
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c CITY OR TOWN: Cumberland	3d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 468 Columbia St. Allegany County Home			
14. FATHER'S NAME First Middle Last: George Leasure		15. MOTHER'S MAIDEN NAME First Middle Last: Rose Valentine					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT: Mr. Russell Leasure	ADDRESS: Brother Cumberland, Md.			

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Thrombosis	"
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Sclerosis	---

Conditions, if any which gave rise to immediate cause (a) stating the underlying cause last

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY? YES ☒ NO ☐
21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A M P M 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R F D No / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: April 17, 1969

ADDRESS (Street, city, town, or ...): Cumberland, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: Apr. 19, 1969	23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery	23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.	
24 FUNERAL DIRECTOR: James F. Scarpelli	ADDRESS: Cumberland, Md.	25a RECD BY REGISTRAR DATE: APR 21 1969	25b REGISTRAR'S SIGNATURE: Charles Yeager	

VR A15ME (5)
10M REV 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

MARYLAND STATE DEPARTMENT OF HEALTH

04767 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04919

1. DECEASED NAME (Type or Print)	First: Robert	Middle: Hall	Last: Loffert	2a. DATE KNOWN OF DEATH / ESTIMATED	Month: April	Day: 30	Year: 1969	2b. HOUR: 3:30 P.M.			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Nov.11,1924	6. AGE (in years last birthday): 44 YRS	IF UNDER YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month: May 1, 1969	Year: 19	2d. HOUR: 3:00a M			
7a. BIRTHPLACE (State or foreign country): Penna.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Allegany Md.								
10. CITY OR TOWN OF DEATH: La Vale	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 420 National Highway	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Industrial Engineer-Glass Ind.	12b. KIND OF BUSINESS OR INDUSTRY								
13a. USUAL RESIDENCE (Where deceased lived, if not hospital or Residence before admission) STATE: Md.	13b. COUNTY: Allegany	13c. CITY OR TOWN: La Vale	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 420 National Highway							
14. FATHER'S NAME First: John	Middle	Last: Loffert	15. MOTHER'S MAIDEN NAME First: Ella	Middle	Last: Kelly						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): WarII	16b. SOCIAL SECURITY NO	17. INFORMANT: Mrs. Edith Loffert	ADDRESS: La Vale, Md.-Wife								

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary occlusion, Left — APPROX. INTERVAL BETWEEN ONSET AND DEATH: Sudden

4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Thrombosis, Left — ": "

DUE TO, OR AS A CONSEQUENCE OF (c): Coronary Sclerosis — ----

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [X] NO [ ]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 8)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: May 1, 1969

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	May 3,1969	Union Cemetery	New Kensington, (W.M.) Pa.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	MAY 6 1969	Charles Judge

VR A15ME (5)
10M REV 1-68

1

04768

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item2 FilmGill 4/9/69 kk

CERTIFICATE OF DEATH

04764

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Dolly	Mae	Lynch	April 12, 1969	9:30A

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Female	White	August 25, 1902	66 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
West Virginia	U S A		Allegany Md.

10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	712 White Avenue	Coning (Retired)	Celanese

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES ☒ NO ☐	712 White Avenue

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Frank		Iliff	Rose		Kenney

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-07-3706	Mrs. James King, Jr. 712 White Ave. Cumberland Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — 2 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitus — 5 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1509

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (~~this hospital~~) attended the deceased from 3/10, 1969, to 4/1, 1969, that (I) (~~we~~) last saw the deceased alive on 3/14 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22c DATE SIGNED
J.A. Pagan					4/2/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
J.A. Pagan, M.D.	1068 National Hwy., LaVale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
Burial	4/4/1969	Sts. Peter & Paul Cath Cem.	Cumberland	Alleg	Md

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Charles E. Hafer	230 Baltimore Ave. Cumberland Md	APR 7 1969	Florence Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 12-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04769 04762

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: EMMA	Middle: CECELIA	Last: LYNCH	2a. DATE OF DEATH Month: APRIL Day: 16, Year: 1969	2b. HOUR: 9:15 P.M.
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: JULY 5, 1893	6. AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): FROSTBURG, MD.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MINERS HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE	12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 147 ORMOND STREET	
14. FATHER'S NAME First: JOSEPH	Middle	Last: MAUREY	15. MOTHER'S MAIDEN NAME First: MARY	Middle	Last: WINNER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	(If yes give war or dates of service): N.A.	16b. SOCIAL SECURITY NO.	17. INFORMANT: MR. JOSEPH LYNCH, 263 CENTENNIAL ST.	Address: FROSTBURG, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary occlusion	Sudden
DUE TO, OR AS A CONSEQUENCE OF (b)	Hypertension	—
DUE TO, OR AS A CONSEQUENCE OF (c)	arterio-sclerosis	—

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4/66

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Obesity

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 4-11, 1969, to 4-16, 1969, that (I) (~~we~~) last saw the deceased alive on 4-16 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: H. C. Diehl, M.D. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22c. DATE SIGNED: 4/19/69.

22d. PHYSICIAN'S NAME (Type): H. C. DIEHL, M.D. 22e. ADDRESS: 39 W. MAIN, FROSTBURG, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 4/19/69	23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY	23d. LOCATION (City or Town): FROSTBURG	(County): ALLEGANY (State): MD.

24a. FUNERAL DIRECTOR: MARILOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG ADDRESS: Marilou M. Sowers

25a. RECD BY REGISTRAR DATE: APR 22 1969 25b. REGISTRAR'S SIGNATURE:

VR A15 (2)
30M REV. 1-68

1

04770

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04763

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Yr	2b HOUR
SCOTT	M.	MANN	APRIL 4 1969	1:45A M

3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	8-31-81	87 YRS.		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	WIDOWED X	ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSP.		

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	LITTLE ORLEANS	NO X	

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
DENTON		MANN	SARAH		SCOTT

16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT Address
	214-14-7835	MEMORIAL HOSP., CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pulmonary failure

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary occlusion progressive

DUE TO, OR AS A CONSEQUENCE OF

(c) Arteriosclerotic heart disease

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

(a) unkn

(b) 1 hour

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Bilateral pneumonites

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES / NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21a ACCIDENT WAS UNDERLYING / CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)

21d. INJURY OCCURRED While at work / Not while at work	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 4-3, 19 67, to 4-3, 19 69, that (I) (we) last saw the deceased alive on 4-3 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c DATE SIGNED
V. V. Dross	MD	X			4-4-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. V. DROSS	CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR ~~CREMATORY~~	23d LOCATION (City or Town) (County) (State)
BURIAL	4.6.69	PINEY PLAINS	RURAL ALLEGANY MD.

24. FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
GROVE FUNERAL HOME	HANCOCK, MARYLAND	APR 10 1969	Charles Lange

VR A15 (1)
45M - 11-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04771

CERTIFICATE OF DEATH

04764

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED NAME (Type or print) First: MARY	Middle: G.	Last: MATHIAS	2a. DATE OF DEATH: APRIL Month 18 Day 1969 Year
2b. HOUR: M			
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: JAN. 15, 1886	6. AGE (In years last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS: HOURS MIN
7a. BIRTHPLACE (State or foreign country): D. C.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md
10. CITY OR TOWN OF DEATH: FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MINERS HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of work ing life, even if retired): HOUSE WIFE	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 36 FROST AVENUE			
14. FATHER'S NAME First: PATRICK	Middle:	Last: McGUIRE	15. MOTHER'S MAIDEN NAME First: CATHERINE Middle: Last: DRISCIL
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 214-01-0063-B	17. INFORMANT Address: MAXWELL J. MATHIAS, FROSTBURG, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Arteriosclerotic heart disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b): Generalized arteriosclerosis — —

DUE TO, OR AS A CONSEQUENCE OF (c): Bursa fibrosis L. front Knee — 1-3-69,

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Senility

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) ~~(this hospital)~~ attended the deceased from 1-3, 19 67, to 4-18, 19 69, that (I) ~~(we)~~ last saw the deceased alive on 4-18 19 69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

22b. SIGNATURE: H. C. Diehl, M.D. DEGREE	ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED: 4/19/69.	
22d. PHYSICIAN'S NAME (Type): H. C. DIEHL, M. D.	22e. ADDRESS: 39 WEST MAIN ST., FROSTBURG, MD.		

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 4-21-69	23c. NAME OF CEMETERY OR CREMATORY: ST. MICHAEL'S CEMETERY	23d. LOCATION (City or Town): FROSTBURG, MD.	(County) (State)
24. FUNERAL DIRECTOR: JOSEPH R. DURST, FROSTBURG, MD.	ADDRESS: 21532	25a. RECD BY REGISTRAR DATE: APR 23 1969	25b. REGISTRAR'S SIGNATURE: Orphans' Court Judge	

VR A15 (4-68)
45M - 1/69

04772 MARYLAND STATE DEPARTMENT OF HEALTH 04765

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First: ROSE Middle: C. Last: MC CORMICK

2a. DATE OF DEATH Month: APRIL Day: 10 Year: 1969 — 2b HOUR: 12:10A

3. SEX: FEMALE — 4. RACE: WHITE — 5. DATE OF BIRTH: 6-21-81 — 6. AGE (In years last birthday): 87 YRS — IF UNDER 1 YEAR: MONTHS / DAYS — IF UNDER 24 HRS.: HOURS / MIN

7a BIRTHPLACE (State or foreign country): MARYLAND — 7b. CITIZEN OF WHAT COUNTRY?: USA — 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 9. COUNTY OF DEATH: ALLEGANY Md

10 CITY OR TOWN OF DEATH: CUMBERLAND — 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIALHOSPITAL — 12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HOUSEWIFE — 12b KIND OF BUSINESS OR INDUSTRY: WON HOME

13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE: MARYLAND — 13b COUNTY: ALLEGANY — 13c. CITY OR TOWN: CUMBERLAND — 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e STREET AND NUMBER: 1105 KENTUCKY AVE.

14. FATHER'S NAME First / Middle / Last: ALEX LEASURE — 15. MOTHER'S MAIDEN NAME First / Middle / Last: FRANCES BRINKER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no — 16b. SOCIAL SECURITY NO — 17 INFORMANT Address: MEMORIAL HOSP., CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Uraemia	6 wks
DUE TO, OR AS A CONSEQUENCE OF (b)	Myocarditis	1 yr
DUE TO, OR AS A CONSEQUENCE OF (c)	Arteriosclerosis	10 yrs

4123

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION — 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED — 20a. AUTOPSY? YES ☐ NO ☐ — 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) — 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 — 21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) — 21f LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from June, 1968, to Apr. 10, 1969, that (I) (we) last saw the deceased alive on Apr 9 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Charles Durrett — DEGREE — ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐ — 22c DATE SIGNED: 4/10/69

22d. PHYSICIAN'S NAME (Type): DR. DURRETT — 22e. ADDRESS: CUMBERLAND, MD.

23a BURIAL, CREMATION REMOVAL (Specify): Burial — 23b DATE: Apr.12,1969 — 23c NAME OF CEMETERY OR CREMATORY: St. Mary's Cemetery — 23d LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md. — 25a. REC'D BY REGISTRAR DATE: APR 14 1969 — 25b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M - 1/69

1

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04773

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04766

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
MARY	M.	McDONALD	APRIL	2	1969	12 P.M.

3. SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN.
FEMALE	W	7-26-1886	82 YRS.				

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8 MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
HARRISONBURG, VIRGINIA	U.S.A.		ALLEGANY Md

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	CUMBERLAND NURSING & CONVALESCENT CENTER	HOUSEWIFE	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☑ NO ☐	340 BALTIMORE AVENUE

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
ISSAC	—	HAWSE	DORCAS	—	GLOVIER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b SOCIAL SECURITY NO	17. INFORMANT Address
No	—	214-16-2033	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	~~ARTERIOSCLEROSIS~~ RESPIRATORY FAILURE	3 HRS
DUE TO, OR AS A CONSEQUENCE OF (b)	PULMONARY CONGESTION	3 HRS
DUE TO, OR AS A CONSEQUENCE OF (c)	ARTERIOSCLEROTIC HEART DISEASE	5 YRS

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last

4172

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

FRACTURE, Right femur

19a DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from MARCH 20, 1969, to April 2, 1969, that (I) (we) last saw the deceased alive on APRIL 1, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☑	MED DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
Ralph V. Smith	MD				3 April

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
ROBERT FREDDIS	500 Irene St, Cumberland

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Cremation	4/4/69	Homewood Crematorium	Pittsburgh, Pennsylvania

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
John J. Hafer, Jr.	230 Balto. Ave., Cumberland, Md.	APR 7 1969	Charles Judge

VR A15 (4)
30M REV 1/68

1

04774

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04767

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Rhoda	R.	McKenzie	4 17 69	M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Female	White	5/5/1889	79 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Md	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Frostburg	Miners Hospital	House Work	Own Home

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md	Allegany	Gilmore	YES ☐ NO ☒	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Louis		Knippenburg	Susanna		Retalic

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT Address
no		Mrs. Raymond Robertson "Daughter" Gilmore, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Myocardial Ischemia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease — 5 years

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis — years

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Fracture left hip - 5 days prior

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from ____, 1956, to April 17, 1969, that (I) (we) last saw the deceased alive on April 16 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	22c. DATE SIGNED
L.R. Miles, M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	4.17.69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L.R. MILES, JR., M.D.	LONACONING, MD, 21539

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
Burial	4/19/69	Memorial Park	Frostburg	A.	Md

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	APR 18 1969	Charles Judge

VR A15(4) 30M REV. 7-68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 5/41
45M 7/69

04775

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04768

1. DECEASED NAME (Type or print) First: WILLIAM	Middle: T.	Last: MC LUCKIE	2a. DATE OF DEATH Month: APRIL Day: 28, Year: 1969
2b. HOUR: 7:25 P.M.			
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 3-24-1893	6. AGE (In years last birthday): 76 YRS. IF UNDER 1 YEAR: MONTHS / DAYS. IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED X / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): RETIRED	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES X NO	13e. STREET AND NUMBER: 1814 FREDERICK ST.,
14. FATHER'S NAME First: ANDREW	Middle	Last: MC LUCKIE	15. MOTHER'S MAIDEN NAME First: ALICE	Middle	Last: LARUE
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 213-22-4290	17. INFORMANT: MEMORIAL HOSPITAL,	Address: CUMB. MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Hepato-renal failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

4 d 2

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): arteriosclerosis, generalized, with

DUE TO, OR AS A CONSEQUENCE OF (c): coronary artery disease aging.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Tracheitis & Cystitis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO X	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 9-27-1960 to 4-26-1969, that (I) ~~(we)~~ last saw the deceased alive on 4-26-1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: W. F. Williams DEGREE: ATTENDING PHYS. X / MED DIRECTOR ☐ / STAFF PHYS. ☐ — 22c. DATE SIGNED: 4-28-69

22d. PHYSICIAN'S NAME (Type): DR. W.F.WMS. — 22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/30/69	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland	
24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service.	ADDRESS: Cumberland, Md 21502	25a. REC'D BY REGISTRAR DATE: MAY 2 1969	25b. REGISTRAR'S SIGNATURE: [illegible]	

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04776

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04769

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b. HOUR
Elmer	Harley	Miller	April	3	1969	10a M

3 SEX	4. RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
Male	White	June 29, 1909	59 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Md.	U.S.A.		Alleganey Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Westernport	111 Donna St.	Laborer	PaperMill

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIM.TS?	13e. STREET AND NUMBER
Md.	Allegany	Westernport	YES ☐ NO ☒	111 Donna

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Howard R. Miller			Hazel		Duckworth

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT	Address
no	217-05-0370	Ethel Miller	Westernport, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Carinomatosis - liver & upper abdomen — APPROX. MATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma head of pancreas — 1 yr.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1570

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
12 Nov 68	Whipple procedure	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f LOCATION Street or R.F.D No.	City or Town	County	State
			April 3,		

22a. I certify that (I) (~~this hospital~~) attended the deceased from July 1, 1968, to ~~January~~, 1969, that (I) (~~we~~) last saw the deceased alive on 1 April 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c DATE SIGNED
Norman Reeves					4 April 1969

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
Norman J Reeves M.D.	Westernport, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
Burial	4/6/69	Philos	Westernport		Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E. P. Bosa	Westernport, Md.	APR 7 1969	Charles Judge

VR A15 (4) 30M REV. 1/68

10 1

04777

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04770

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: FRANK	Middle: WILLIAM	Last: MILLER	2a. DATE OF DEATH: Month 4	Day 9	Year 69	2b. HOUR: 10:30 P.M.
3. SEX: MALE	RACE: WHITE	5. DATE OF BIRTH: 9-9-08	6. AGE (In years last birthday): 60 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY				Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Machine Opr.	12b. KIND OF BUSINESS OR INDUSTRY: CELANESE				
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: W. VA.	13b. COUNTY: MINERAL	13c. CITY OR TOWN: RIDGELEY	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 39 SECOND AVE.			
14. FATHER'S NAME First: JOHN	Middle: W.	Last: MILLER	15. MOTHER'S MAIDEN NAME First: (BAKER) ESSIE	Middle:	Last: MILLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-07-4609	17. INFORMANT: HOSPITAL RECORDS	Address: 900 SETON DR. CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		Approximate Interval Between Onset and Death
Immediate Cause (a)	Intestinal Obstruction	12 hrs.
Due to, or as a consequence of (b)	Generalized Carcinomatosis	6 mos.
Due to, or as a consequence of (c)	Carcinoma of Cecum	2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

1550

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from March, 19 69 to April 9, 19 69, that (I) (we) last saw the deceased alive on April 9, 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: J. A. Pagan	DEGREE: ATTENDING PHYS [X] MED. DIRECTOR [ ] STAFF PHYS [ ]	22c. DATE SIGNED: 4-10-69		
22d. PHYSICIAN'S NAME (Type): J. A. PAGAN, MD	22e. ADDRESS: 1068 NATIONAL HWY., LA VALE, MD.			

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/12/69	23c. NAME OF CEMETERY OR CREMATORY: Zion Memorial Burial Park	23d. LOCATION (City or Town) (County) (State): nr. Cumberland, Allegany, Md.	
24. FUNERAL DIRECTOR: GEORGE'S FUNERAL HOME	ADDRESS: GREENE ST. CUMBERLAND, MD.	25a. REC'D BY REGISTRAR DATE: APR 14 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04773

CERTIFICATE OF DEATH

04771

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
William	Howard	Mintdrop	Apr.	4	1969	8 AM

3. SEX	4 RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
Male	White	March 11, 1895	74 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Md.	USA		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	124 W. Oldtown Rd.	Crane Operator	Cement

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☒ NO ☐	124 W. Oldtown Road

14 FATHER'S NAME First Middle Last	15 MOTHER'S MAIDEN NAME First Middle Last
Criss Mintdrop	Gertrude Hughes

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT Address
no		Mrs. Mae Mintdrop, Cumberland, Md.-Wife

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Congestive Heart Failure, Recurrent	Last 5 days
DUE TO, OR AS A CONSEQUENCE OF (b)	Aortic Stenosis advanced	" "
DUE TO, OR AS A CONSEQUENCE OF (c)	Coronary Arteriosclerotic Cardiovascular Disease	" "

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I **certify** that (I) (this hospital) attended the deceased from [illegible] 19[illegible] to [illegible] 19[illegible] that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(have)~~ (did) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE				22c. DATE SIGNED
David T. Rees M.D.		ATTENDING PHYS ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	Apr. 6, 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Dr. David T. Rees, M.D.	702 Montgomery Ave., Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Apr. 7, 1969	Restlawn Mem. Gardens	La Vale, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	APR 8 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner Office along with form 893. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04779

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04772

1 DECEASED-NAME (Type or Print) First: WILLIAM	Middle:	Last: MORGAN	2a DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: 4/ Day: 20 Year: 1969	2b HOUR: 12:3 A M				
3 SEX: MALE	4 RACE: WHITE	5 DATE OF BIRTH: 1/12/05	6 AGE (in years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c DATE PRONOUNCED DEAD Month: 4/ Day: 20 Year: 1969	2d HOUR: 12:30 A M	
7a BIRTHPLACE (State or foreign country): MARYLAND	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY Md					
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): D.O.A. SACRED HEART HOSP.	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): COAL MINER	12b KIND OF BUSINESS OR INDUSTRY: COAL MINES					
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: R.F.D. 1 FROSTBURG	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET AND NUMBER (NATIONAL) R.F.D.1, FROSTBURG, MD.				
14 FATHER'S NAME First: WILLIAM	Middle:	Last: MORGAN	15 MOTHER'S MAIDEN NAME First: CARRIE	Middle:	Last: SPEIR			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO	(If yes give war or dates of service): N.A.	16b SOCIAL SECURITY NO: 213-09-1905	17 INFORMANT: MRS. WILLIAM MORGAN, R.F.D.1, BOX 264 FROSTBURG, MD.					

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b TIME OF INJURY Month, Day Year HOUR A.M P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [ ], Inquiry [X], and in my opinion death resulted from. Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, MD.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [ ]
ADDRESS(Street, city town, or county)

22b. DATE SIGNED: 4/20/69

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
BURIAL	4/22/69	FROSTBURG MEM. PARK	FROSTBURG, ALLEGANY, MD.

24 FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
MARILOU M. SOWERS Marilou M. Sowers	HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG	APR 24 1969	J. Charles Judge

VR A15ME 151
10M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and in any event, within 72 hours after death, should be filed with the State Dept. of Health prior to burial, cremation, or removal.

VR A15 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04780

04773

1 DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
(BABY BOY)		MORRIS	APRIL	7	1969	3:25 PM

3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN.
MALE	WHITE	APRIL 7, 1969	— YRS.			2	15

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
MARYLAND	USA		ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES X NO ☐	16 VIRGINIA AVE.

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
FRANCIS	E.	MORRIS	SHIRLEY	C.	HARPER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
no	none	MEMORIAL HOSP. CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Prematurity

777X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES ☐ NO X	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS ☐	22c DATE SIGNED
[signature]	M.D.				

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. NADEAU M.D.	CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Apr. 8, 1969	St. Joseph's Cemetery	Midland, Md. Allegany

24. FUNERAL DIRECTOR ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	APR 9 1969	[signature]

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04781

CERTIFICATE OF DEATH

04774

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
CLARICE	S.	MYERS	4 8 69	3:40 P.M.

3. SEX	4. RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOUR. / MIN
FEMALE	WHITE	07 01 16	52 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED XX / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
W. VA.	USA	MARRIED XX	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND, MD.	SACRED HEART HOSPITAL	POST MISTRESS	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	ALLEGANY	RAWLINGS	YES X NO	NONE

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
CHARLES		SHOBE	MOLLIE [redacted]	HEDRICK	SHOBE

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	217 07 4758	SACRED HEART HOSPITAL	~~900 SETON DRIVE~~ CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Adeno-Carcinoma, Breast & Generalized Metastases — APPROXIMATE INTERVAL, BETWEEN ONSET AND DEATH: 3 years

DUE TO, OR AS A CONSEQUENCE OF (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO	

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
		N/A

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State
	N/A				

22a. I certify that (I) (~~this hospital~~) attended the deceased from 4-6, 19 69, to 4-8, 19 69, that (I) (~~we~~) last saw the deceased alive on 4-8, 19 69 and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED
William R Wolverton MD		X			4/9/69

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. WILLIAM R. WOLVERTON	955 FREDERICK STREET - CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4/11/69	Hillcrest Burial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
WILCOX-MERRITT FUNERAL SERVICE 404 DECATUR ST. CUMBERLAND, MD.	APR 14 1969	Marian Snider

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (6)
45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M 1-69

04782

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04775

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month	Day	Year	2b HOUR
CLARA	A.	NILAND	4	5	69	7:05A

3 SEX	4 RACE	5 DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN
FEMALE	WHITE	4-20-75	93 YRS.				

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
MARYLAND	U.S.A.		ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Housewife	Own Home

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES ☒ NO ☐	724 NORTH CENTRE ST.

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
PHILLIP		CLARKE	CATHERINE		SHANNON

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b SOCIAL SECURITY NO	17 INFORMANT Address
no		MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Anemia — APPROX MATE INTERVAL BETWEEN ONSET AND DEATH: 3 yrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (c) Infected Duodenal Ulcer — 2 mos

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from March 6, 1969, to April 5, 1969, that (I) (we) last saw the deceased alive on April 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS ☒	MED DIRECTOR ☐	STAFF PHYS. ☐	22c DATE SIGNED
Clay F. Durrett					4/5/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. CLAY DURRETT	CUMBERLAND, MD.

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	Apr. 8, 1969	St. Patrick's Cemetery	Cumberland, Allegany, Md.

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	APR 8 1969	Charles Judge

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15 (M)
45M - 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04783 — 04776

1. DECEASED NAME (Type or print)	First: LEO	Middle: JOSEPH	Last: O'BAKER	2a. DATE OF DEATH: Month APRIL Day 23 Year 1969	2b HOUR: 1:30A	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 11-17-98	6. AGE (In years last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country): PA.	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired): DISABLED	12b KIND OF BUSINESS OR INDUSTRY			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MD.	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CUMBERLAND	13d INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: 402 WAVERLY TERRACE		
14 FATHER'S NAME: First JOHN Middle Last O'BAKER	15 MOTHER'S MAIDEN NAME: First NANCY Middle Last ZORN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 220-10-2007	17 INFORMANT: Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a) (b) and (c))

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): CARCINOMA - METASTATIC - LIVER — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 mos

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): CARCINOMA - STOMACH — 6 mos

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): —

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from _____, 1963, to APRIL 23, 1969, that (I) (~~we~~) last saw the deceased alive on APRIL 29 1969, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. Bauer — DEGREE: ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ] — 22c. DATE SIGNED: APR. 26, 1969

22d PHYSICIAN'S NAME (Type): DR. BAUER — 22e ADDRESS: CUMBERLAND, MD.

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town)	(County)	(State)
Burial	4/25/1969	Mt. Herman Cemetery	Near Cumberland	Alleg	Md

24 FUNERAL DIRECTOR — ADDRESS: Charles E. Hafer, 230 Balto Ave. Cumberland Md. — 25a RECD BY REGISTRAR DATE: APR 28 1969 — 25b REGISTRAR'S SIGNATURE: Charles Judge

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

04784

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04777

1 DECEASED NAME (Type or Print)	First: MARY	Middle: A.	Last: OFTEN	2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☒	Month: April	Day: 10	Year: 1969	2b. HOUR: 3 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: NOV. 19, 1905	6. AGE (In years last birthday): 63 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month April 18, Day, Year 1969	2d. HOUR: 8 a M
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.				
10. CITY OR TOWN OF DEATH: FROSTBURG	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R#2 Frostburg	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE WIFE	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: ECKHART	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER			
14. FATHER'S NAME First: JOHN	Middle:	Last: ROSENBERGER	15. MOTHER'S MAIDEN NAME First: GRACE	Middle:	Last: LARUE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 218-32-8338	17. INFORMANT: EMORY ROSENBERGER	ADDRESS: RT. 2, FROSTBURG, MD.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY.

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary Occlusion	Sudden
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO, OR AS A CONSEQUENCE OF (b)	Coronary Sclerosis	---
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: April 18, 1969

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	4-21-69	HILLCREST BURIAL PARK	CUMBERLAND, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. R. DURST, FROSTBURG, MD.	21532	APR 23 1969	Charles Judge

VR A15ME .5M
10M REV. 1/68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

04785

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04778

1 DECEASED-NAME (Type or Print) First	Middle	Last	2a DATE KNOWN OF DEATH ESTIMATED	2b HOUR
FRANK	JOSEPH	O'GRINCE	X Month Day Year APRIL 10, 1969	9:30 P M

3 SEX	4. RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS HOURS	IF UNDER 24 HRS MIN	2c DATE PRONOUNCED DEAD Month Day Year 19	2d HOUR
MALE	WHITE	FEB. 13, 1933	36 YRS					APRIL 10, 1969	9:30 P M

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
ECKHART, MD.	U.S.A.		ALLEGANY Md.

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL--DOA	LABORER	CEMENT FACT.

13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
OHIO	PORTAGE	RAVENA	YES ☐ NO X	R.F.D. 5, Trailer Court

14. FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
LOUIS		O'GRINCE	FRANCES		BODLINGER

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16b SOCIAL SECURITY NO.	17 INFORMANT
YES	KOREA	220-32-4092	MR. LOUIS O'GRINCE, 130 CENTRE ST., FROSTBURG, MD. 21532

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) CORONARY THROMBOSIS, LEFT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — --

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES X NO ☐

20.a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED: APRIL 10, 1969

ADDRESS (Street, city, town, state): CUMBERLAND, MARYLAND

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	4/14/69	ST. ANN'S CEMETERY	GARRETT, MD.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
MARILOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG	APR 15 1969	Charles Judge

VR A15ME (5) 10M REV 1/68

Item1 14786 12 5/6/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

0477

Item13 Film 412 4/30/69 kk

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Temperence	Scott	Pettet	April	13	1969	9:30 P.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	10/16/1873	95 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A.	WIDOWED [X]	Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sylvan Retreat		

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES [X] NO [ ]	North Mechanic St. Unknown

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Winfield	Scott	Jordan	Harriett		Shuck

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	219-54-2196	Kathleen Hose, Oldtown, Maryland

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4369 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis — 4yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from April 15, 1967, to April 13, 1969, that (I) (we) last saw the deceased alive on April 13 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
George M. Simons	M.D.	[X]	[ ]	[ ]	4/15/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
George M. Simons, M.D.	Memorial Hospital, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	4/16/1969	Rose Hill Cemetery	Cumberland	Alleg	Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Hafer, Jr.,	230 Balto Ave. Cumberland, Md.	APR 16 1969	Thomas Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A15 (4) 30M REV 1-68

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04787 — 04780

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: IRENE	Middle: B	Last: REITH	2a. DATE OF DEATH: Month 4 Day 3 Year 69	2b. HOUR: 12:10P
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 6-1-04	6. AGE (In years last birthday): 64 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY		Md
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 339 BEDFORD ST.	
14. FATHER'S NAME First: CONRAD	Middle:	Last: HERPICH	15. MOTHER'S MAIDEN NAME First: Maggie	Middle: M	Last: Wiebel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: MEMORIAL HOSPITAL	Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 1 DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myelomic Leukemia — 6 mos

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

1241

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)

21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work [ ] Not while at work [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC)

21f. LOCATION Street or R.F.D. No. / City or Town / County / State

Cumberland Allegany Md

22a. **I certify** that (I) (this hospital) attended the deceased from 3/26/69, 19____, to 4/3/69, 19____, that (I) (~~saw~~) last saw the deceased alive on 4/3/69 19____, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (~~saw~~) (did) (~~did not~~) view the body after death.

22b SIGNATURE: [signature] M.D. DEGREE — ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]

22c. DATE SIGNED: 4/4/69

22d. PHYSICIAN'S NAME (Type): DR. R. J. WILLIAMS

22e ADDRESS: CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 4/7/69	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park	23d LOCATION (City or Town): Cumberland	(County): Alleg any	(State): Md
24 FUNERAL DIRECTOR: William G. Kight	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: APR 8 1969	25b. REGISTRAR'S SIGNATURE: [signature] Judge		

VR A15 (2)
45M - 1/69

1

04783

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04781

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 DECEASED NAME (Type or print)	First: WALTER	Middle: ELWOOD	Last: RITCHIE	2a DATE OF DEATH: APRIL Month 16 Day 1969	2b HOUR: 4:40A
3 SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 7-5-11	6. AGE (In years last birthday): 57 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): PA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY Md		
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Machine oper.	12b. KIND OF BUSINESS OR INDUSTRY: Celanese		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e. STREET AND NUMBER: 11 N. LEE ST.	
14 FATHER'S NAME First: IRVIN	Middle: J.	Last: RITCHIE	15 MOTHER'S MAIDEN NAME First: BERTHA	Middle: C.	Last: TEETS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No,	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 217-10-5540	17 INFORMANT: MEMORIAL HOSPITAL,	Address: CUMBERLAND, MD.	

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 hrs

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Occlusion of Left Anterior Coronary Artery — 4 hrs

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis + Myocardial Hypertrophy —

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No / City or Town / County / State	

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from 4/10, 19 68, to 4/16, 19 69, that ~~I~~ (we) last saw the deceased alive on 4/16, 19 69, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: George M. Simons — DEGREE: ATTENDING PHYS [ ] MED DIRECTOR [X] STAFF PHYS [ ] — 22c. DATE SIGNED: 4/16/69

22d. PHYSICIAN'S NAME (Type): George M. Simons, M. D. — 22e. ADDRESS: Memorial Hosp. Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/18/69	23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park,	23d. LOCATION (City or Town): Cumberland,	(County): Allegany (State): Md.
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: APR 21 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15-4
45M - 1-69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal. If in any event within 72 hours after death.

04789

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04782

1 DECEASED-NAME (Type or Print)	First: De Coursey	Middle: A.	Last: Roth	2a DATE OF DEATH: KNOWN ☐ EST-MATED ☐	Month: Apr.	Day: 26	Year: 1969	2b HOUR: 11A M			
3 SEX: MALE	4 RACE: White	5 DATE OF BIRTH: Feb. 14, 1896	6 AGE (In years last birthday): 73 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month Apr. Day 26 Year 69	2d HOUR: 11A M				
7a BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: USA	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH: Allegany Md.								
10. CITY OR TOWN OF DEATH: Cumberland	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): D.O.A. Memorial H.	12a U.S.A. OCCUPATION (Kind of work done during most of work life, even if retired): Retired Carman	12b KIND OF BUSINESS OR INDUSTRY: Railroad								
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Md.	13b COUNTY: Allegany	13c CITY OR TOWN: Cumberland	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e STREET AND NUMBER: 9 Long Drive							
14 FATHER'S NAME First Middle Last: David O. Roth	15. MOTHER'S MAIDEN NAME First Middle Last: Margaret L. Weber										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes (If yes give war or dates of service): War I-Marines	16b SOCIAL SECURITY NO	17. INFORMANT ADDRESS: Mrs. Mabel Roth, Cumberland, Md.-Wife									

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY

		APPROX MATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	CORONARY OCCLUSION	SUDDEN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 — DUE TO, OR AS A CONSEQUENCE OF (b)	CORONARY SCLEROSIS	--
DUE TO, OR AS A CONSEQUENCE OF (c)		

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: April 26, 1969

ADDRESS (Street, city, town, or county): Rt. 9, Cumberland, Md.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	Apr. 29, 1969	Hillcrest Burial Park	Cumberland, Allegany, Md.

24 FUNERAL DIRECTOR ADDRESS	25a REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	APR 29 1969	

VR A15ME (5) 10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

n4790

04783

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Leo	Stuart	Rowan	April 2, 1969	12:20 P

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Male	White	10/19/81	87 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Md.	U.S.A.	WIDOWED [X]	Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sylvan Retreat	Painter	Self emp.

13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Lonaconing	YES [X] NO [ ]	

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Patrick	Rowan		Anna	Barkely	

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
no	210-10-5955	Lillian Kiddy	Lonaconing, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C V A
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4369

APPROX MATE INTERVAL BETWEEN ONSET AND DEATH: Yrs

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from April 15, 19 67, to April 2, 19 69, that (I) (we) last saw the deceased alive on April 1 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
George M. Simons	M.D.	[X]	[ ]	[ ]	4/4/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
George M. Simons	Memorial Hospital, Cumberland, Md. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	4/5/69	Oakhill	Lonaconing		Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. J. Beal	Westernport, Md.	APR 8 1969	Blanche Dudas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Page 3, Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

04791 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04784

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)	First: Harry	Middle: Francis	Last: Ruby	2a DATE KNOWN OF DEATH ESTIMATED	Month: April	Day: 7,	Year: 1969	2b HOUR: 11 AM			
3 SEX: Male	4 RACE: White	5 DATE OF BIRTH: March 1, 1887	6 AGE (In years last birthday): 82 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN	2c DATE PRONOUNCED DEAD: Month: April	Day: 7,	Year: 1969	2d HOUR: AM 11:00		
7a. BIRTHPLACE (State or foreign country): Maryland	7b CITIZEN OF WHAT COUNTRY?: U.S.A.	8 MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: Allegany Md.								
10. CITY OR TOWN OF DEATH: R 9 , Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): R 9 Baltimore Pike (DOA)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Roads Supervisor	12b KIND OF BUSINESS OR INDUSTRY: County Roads								
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: Maryland	13b COUNTY: Allegany	13c CITY OR TOWN: Flintstone	13d INSIDE CITY LIMITS? YES [ ] NO [X]	13e STREET AND NUMBER: Route #2							
14 FATHER'S NAME First: John	Middle	Last: Ruby	15 MOTHER'S MAIDEN NAME First: Catherine	Middle	Last: Imes						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b SOCIAL SECURITY NO: 214-36-7077	17. INFORMANT ADDRESS: Grant L. Ruby, Rt.#2, Flintstone, Md. (Son)									

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last — 410.9

(b) CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES [ ] NO [X]

21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a **I certify** that I took charge of the remains described above, held an Autopsy [ ], Inspection [XX], Inquiry [XX] and in my opinion death resulted from. Natural causes [XX], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b DATE SIGNED: April 7, 1969

ADDRESS (Street, city, town, or county): Cumberland, Maryland

23a BURIAL CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/9/69	Beans Cove Methodist Cem.	Beans Cove, Bedford, Penna.

24. FUNERAL DIRECTOR	ADDRESS	25a RECD BY REGISTRAR	25b REGISTRAR'S SIGNATURE
Charles E. Hafer	Charles E. Hafer, 230 Balto. Ave., Cumberland, Md.	APR 9 1969	Frances Yingling

VR A15ME (5)
10M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 45M 1/69

04792

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04785

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
JOHN	J.	SCHLERETH	4	24	69	2:25PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
MALE	REMARK WHITE	6-17-08	60 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U.S.A.	MARRIED X	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Retired Mechanic	Celanese Textile

13a. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CUMBERLAND	YES X NO	554 WINIFRED RD, K

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
AUGUST		SCHLERETH	MARY		GALSTER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	Address
no		MEMORIAL HOSPITAL	CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart Failure, Rt + left — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

Conditions if any, which gave rise to immediate cause (a) stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) due to Myocardial Fibrosis — 15 years

DUE TO, OR AS A CONSEQUENCE OF (c) Nervous Myocardial Infarction — 15 years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Coronary Thrombosis Arteriosclerotic Heart Disease — 15 yrs / 2 yrs

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from _____, 19 68, to 4/24, 19 69, that (I) (we) last saw the deceased alive on 4/24 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I), (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS ☐	MED DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
[signature]					4/25/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. S. G. WEISMAN	CUMBERLAND, MD.

23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4-28-1969	St. Mary's Cemetery	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
James F. Scarpelli, Cumberland, Md.	APR 29 1969	[signature]

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04793

CERTIFICATE OF DEATH

04786

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print)	First: Mary	Middle: Lillian	Last: Schurg	2a. DATE OF DEATH: Month April Day 5 Year 1969 at 3:50 P.M.	2b. HOUR: P.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 10/6/1903	6. AGE (In years last birthday): 65 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Allegany County Md.		
10. CITY OR TOWN OF DEATH: Cumberland	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Frostburg	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: Centenial Street	
14. FATHER'S NAME First: William	Middle	Last: Bishop	15. MOTHER'S MAIDEN NAME First: Rose	Middle	Last: Winebrenner
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO: 216-10-6806D	17. INFORMANT: P. O. Box 599, Allegany County Infirmary records.	Address: Cumberland, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute renal insufficiency — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Approx 10 days
DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic Disease — Many years
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis — Many years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Old C.V.A. & Left sided hemiplegia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from Oct. 22, 1964, to April 5, 1969, that (I) (we) last saw the deceased alive on April 5, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: John A Foppa	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒	22c. DATE SIGNED: April 7-1969			
22d. PHYSICIAN'S NAME (Type): John A Foppa M.D.	22e. ADDRESS: Memorial Hospital, Cumberland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4-5-69	23c. NAME OF CEMETERY OR CREMATORY: Bittinger Cemetery	23d. LOCATION (City or Town) (County) (State): Bittinger, Garrett, Md.		
24. FUNERAL DIRECTOR ADDRESS: Joseph R. Durst, Sr., Frostburg, Md. 21532	25a. RECD BY REGISTRAR DATE: APR 9 1969	25b. REGISTRAR'S SIGNATURE			

VR A15 (M)
30M REV 7-68

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18 Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Exominer's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 3 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

04794 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 04787

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print)	First: Edna	Middle: Irene	Last: Shipley	2a. DATE KNOWN ☒ OF DEATH ESTIMATED ☐	Month: Apr.	Day: 3	Year: 19	2b. HOUR: 7:45 A M	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 3/ 8/1898	6. AGE (in years last birthday): 71 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month: April	Day: 3	Year: 1969	2d. HOUR: 9:45 A M
7a. BIRTHPLACE (State or foreign country): Penna.	7b. CITIZEN OF WHAT COUNTRY?: U S A	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md						
10. CITY OR TOWN OF DEATH: Little Orleans	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): At Home-Little Orleans Md	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Housewife	12b. KIND OF BUSINESS OR INDUSTRY						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Little Orleans	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: -----					
14. FATHER'S NAME First: William	Middle: [illegible]	Last: Sowers	15. MOTHER'S MAIDEN NAME First: Elmira	Middle:	Last: Bennett				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT ADDRESS: Marie Teeter, Route 2, Flintstone, Md.							

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4104

DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — --

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: April 3, 1969

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	Apr. 5, 1969	Fairview Christian Cem	Near Artemas	Bedford	Penna

24. FUNERAL DIRECTOR ADDRESS: John J. Hafer, Jr. 230 Balto Ave. Cumberland

25a. REC'D BY REGISTRAR: Md APR 7 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME (5)
10M REV 1/68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of the death.

VR A 15 (1) 45M 11/69

04795

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04788

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
GLENNA	JUNE	SMITH	APRIL 29 1969	6:30A

3 SEX	4 RACE	5. DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN
FEMALE	WHITE	6-27-31	37 YRS.		

7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	Housekeeper	At Home

13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
MD.	ALLEGANY	CUMBERLAND	YES [X] NO [ ]	507 WARREN ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
GEORGE		MCDONALD	ERMA	E.	ATHEY

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT Address
No	220-28-7598	MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a) Acute Cardiac failure ? anasarca — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1714X

DUE TO, OR AS A CONSEQUENCE OF (b) (?) Radiation myocarditis ? Pulm. ? mo.

DUE TO, OR AS A CONSEQUENCE OF (c) Treatment for bilat Breast Ca — 2 1/2 yrs.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
2 wks ago	Bilat. Breast Ca	YES [X] NO [ ]	yes

21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While [ ] at work Not while [ ] at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19 __, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS [X]	MED DIRECTOR [ ]	STAFF PHYS. [ ]	22c DATE SIGNED
[signature]	MD				

22d PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. MIRKIN	CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	5/1/69	Sunset Memorial Park	Cumberland Allegany Maryland

24 FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	MAY 5 1969	Charles Judge

Item24 FilmG412 5/5/69 kk
&Items5,7,23

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours

VR A15 (4, 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04796

CERTIFICATE OF DEATH

04789

1 DECEASED-NAME (Type or print) First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR
PHILIP	D	SMITH	APRIL 17 1969	5:40

3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
MALE	WHITE	July 21, 1900	68 YRS		

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
Penna. W./ N.A.	USA	WIDOWED X	ALLEGANY Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL		

13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e. STREET AND NUMBER
W. VA.		PAW PAW	YES X NO	

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last

16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17 INFORMANT Address
		MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18 **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1 DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Pulmonary Embolism

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral CVD.

DUE TO, OR AS A CONSEQUENCE OF (c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 days

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES / NO X	

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a **I certify** that (I) ~~(this hospital)~~ attended the deceased from 4/17/69, 19___, to 4/17/69, 19___ ~~that~~ (I) (we) last saw the deceased alive on 4/17/69, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above. (I) (we) ~~(did) (did not)~~ view the body after death

22b SIGNATURE [signature] DEGREE ATTENDING PHYS X MED DIRECTOR ☐ STAFF PHYS. ☐ 22c DATE SIGNED 4/25/69

22d PHYSICIAN'S NAME (Type) DR. R. J. WILLIAMS 22e ADDRESS 122 S. CENTRE ST., CUMBERLAND, MD.

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4/20/1969	Camp Hill Cemetery	Paw Paw Morgan W.Va.

24 FUNERAL DIRECTOR ADDRESS	25a RECD BY REGISTRAR DATE	25b REGISTRAR'S SIGNATURE
Johnson Funeral Home- Paw Paw, West Virginia	APR 28 1969	[signature]

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04797

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04790

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
WALTER	THOMAS	SMITH	APRIL 8, 1969	PM 10:55

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
MALE	WHITE	1-5-14	55 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND, Barton	USA	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	SACRED HEART HOSPITAL	RETIRED TECH.	Rocket Plant

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	CRESAPTOWN	YES [X] NO [ ]	RT. #6 REDWOOD ST.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
THOMAS		SMITH	ANNIE		LYONS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO		213-03-4740	SACRED HEART HOSPITAL PTS. CHART	900 SETON DRIVE CUMBERLAND, MD. 21502

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) Bilateral Lobar Pneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [X] NO [ ]	Yes

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from March, 19 69, to April 8 19 69, that (I) (we) last saw the deceased alive on April 8 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
[signature]	ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]	4-10-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
J.A. PAGAN, M.D.	1068 NATL HWY., LA VALE, CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/12/69	Hillcrest Burial Park	Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
GEORGE FUNERAL HOME	202 GREENE ST. CUMBERLAND, MD. 21502	APR 14 1969	[signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R)
45M - 1-68

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
04793 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
04793

1 DECEASED NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month Day Year	2b. HOUR
Louis	C.	Soethe	April 2 19 69	9:05 PM

3. SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS HOURS / MIN.	2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Male	White	Sept 3, 1922	46 YRS			April 2, 1969 19	9:05PM

7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9 COUNTY OF DEATH
Md.	USA		Allegany Md

10 CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp. to give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b KIND OF BUSINESS OR INDUSTRY
Cumberland	Memorial Hospital-DOA	Sales Representat.	Food

13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER
Md	Allegany	Cumberland	YES ☒ NO ☐	672 Fayette St.

14 FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
William	Louis	Soethe	Mary		Brookman

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT	ADDRESS
No	213-12-9985	Mrs. Marian Soethe	Cumberland, Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I DEATH WAS CAUSED BY

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary OCCLUSION	SUDDEN
DUE TO, OR AS A CONSEQUENCE OF		
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b)	CORONARY THROMBOSIS	H
DUE TO, OR AS A CONSEQUENCE OF		
(c)	CORONARY SCLEROSIS	------

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED?	20 AUTOPSY?
		YES ☒ NO ☐

21a EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Cumberland, Md.

22b DATE SIGNED APRIL 2, 1969

23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/7/69	St. Peter&Paul Cem.	Cumberland Allegany Md.

24. FUNERAL DIRECTOR	ADDRESS	25a REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
William G. Kight	Cumberland, Md.	DATE APR 8 1969	Charles Judge

VR A15ME (5)
10M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

04799 — 0479

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: MARY	Middle: I.	Last: SOLOMON	2a. DATE OF DEATH: APRIL (Month) 25 (Day) 69 (Year)	2b. HOUR: 8:10 AM
3. SEX: FEMALE	4. RACE: WHITE	5. DATE OF BIRTH: 9-22-80	6. AGE (In years last birthday): 88 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): WEST VA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: ALLEGANY Md.		
10. CITY OR TOWN OF DEATH: CUMBERLAND, MD.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): HWF	12b. KIND OF BUSINESS OR INDUSTRY: HOME		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: FROSTBURG	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: RT. #2 BOX 86	
14. FATHER'S NAME: First JOHN	Middle W.	Last CALHOUN	15. MOTHER'S MAIDEN NAME: First SARAH	Middle FRANCES	Last NAIR
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: PTS CHART	Address: SACRED HEART HOSPITAL 900 SETON DRIVE CUMB., MD. 21502		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a): Uremia — Nephrosclerotic type — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 wk

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Heart Disease - Arteriosclerotic — 10 yr

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pulmonary Edema — Bronchopneumonia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY: HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No.	City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19__, to 4/25, 1969, that (I) (we) last saw the deceased alive on 4/24 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐ — 22c. DATE SIGNED: 4/25/69

22d. PHYSICIAN'S NAME (Type): S.G. WEISMAN, M.D. — 22e. ADDRESS: 59 GREENE ST., CUMB., MD. 21502

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 4/27/69	23c. NAME OF CEMETERY OR CREMATORY: PORTER CEMETERY	23d. LOCATION (City or Town) (County) (State): ECKHART, ALLEGANY, MD.	
24. FUNERAL DIRECTOR: Marlow M. Sowers HAFER-SOWERS FUNERAL HOME	ADDRESS: 60 MAIN ST., FROSTBURG	25a. RECD BY REGISTRAR DATE: APR 29 1969	25b. REGISTRAR'S SIGNATURE: Presiding Judge	

VR A15 M
45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04800

CERTIFICATE OF DEATH

04793

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day		2b. HOUR
HUGH	M.	TERNENT	April	6	1969	9A. M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	11/20/1913	55 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
MD.	USA.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Lonaconing	Scotch Hill	Luke Paper Mill	Paper

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	Allegany	Lonaconing	YES ☒ NO ☐	Scotch Hill

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Willial J. Ternent	Barbara McMillian

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO	17. INFORMANT Address
No	220-10-1775	Thelma Ternent, Lonaconing, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c))

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary - Occlusion (WIFE) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

3949

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) apex. Mitral stenosis Cleveland clinic — 2 mos -

DUE TO, OR AS A CONSEQUENCE OF (c) H.C.V.D. — Years.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from Jan. , 1968 to April 6 , 1969, that (I) (we) last saw the deceased alive on 4/3/69 — 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John B. Davis, M.D.		☒	☐	☐	4/7/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John B. Davis, M.D.	2 Broadway, Frostburg, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	April, 9, 98	Memorial Park	Frostburg, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. RECD BY REG STRAR DATE	25b. REGISTRAR'S SIGNATURE
GEORGE EICHHORN	Lonaconing, Md.	APR 9 1969	Hilarie Jones

VR A15
30M REV. 11-68

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13-4(J)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04801

04794

1. DECEASED-NAME (Type or print)	First: Walter	Middle: Clark	Last: Uhl	2a. DATE OF DEATH: April Month 21 Day 1969		2b. HOUR: 11:55 AM	
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Oct. 22, 1912	6. AGE (In years last birthday): 56 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Allegany Md				
10. CITY OR TOWN OF DEATH: Westernport	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): 207 Central Ave.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Labor	12b. KIND OF BUSINESS OR INDUSTRY: Paper Mill				
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE: Maryland	13b. COUNTY: Allegany	13c. CITY OR TOWN: Westernport	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 207 Central Ave.			
14. FATHER'S NAME First: Edgar	Middle	Last: Uhl	15. MOTHER'S MAIDEN NAME First: Bertha	Middle	Last: Clark		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): yes	(If yes, give war or dates of service): WW 2	16b. SOCIAL SECURITY NO.: 216 07 9649	17. INFORMANT: Ester Uhl	Address: Westernport, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY.

IMMEDIATE CAUSE (a): Squamous Carcinoma Left Lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 mo

DUE TO, OR AS A CONSEQUENCE OF

(b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1621

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I **certify** that (I) (this hospital) attended the deceased from Jan 9, 1969, to April 21, 1969, that (I) (we) last saw the deceased alive on April 20 1969 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Robert W. Bess Jr. DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: April 22, 1969

22d. PHYSICIAN'S NAME (Type): Robert W. Bess Jr. — 22e. ADDRESS: Piedmont, W.Va.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/24/69	Philos Cem.	Westernport, Md. Allegany

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
E.S. Boal	Westernport, Md.	APR 24 1969	Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04802

CERTIFICATE OF DEATH

04795

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED NAME (Type or print): First RUSSELL; Middle P.; Last WALTERS
2a. DATE OF DEATH: APRIL Month 16 Day 1969 Year; 2b. HOUR: 2:10A M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 4-12-96
6. AGE (In years last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS, DAYS | IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): PENNA.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired): Laborer
12b. KIND OF BUSINESS OR INDUSTRY: Tire Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE: PENNA.
13b. COUNTY: Bedford Co.
13c. CITY OR TOWN: CLEARVILLE
13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: ROUTE 1
14. FATHER'S NAME First HEZEKIAH; Middle; Last WALTERS
15. MOTHER'S MAIDEN NAME First RACHEL; Middle; Last WILKINSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO: 170-12-3952
17. INFORMANT Address: MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)
PART 1. DEATH WAS CAUSED BY
IMMEDIATE CAUSE (a): Cholecystitis — APPROX. INTERVAL BETWEEN ONSET AND DEATH: 25 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Cholelithiasis & Cholecystitis — 75 days
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Old Myocardial infarction - Arteriosclerotic Heart Disease

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from Summer, 19 67, to 4/16, 19 69, that (I) (we) last saw the deceased alive on 4/15 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22c. DATE SIGNED: 4/16/69
22d. PHYSICIAN'S NAME (Type): DR. WEISMAN
22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 4/19/69
23c. NAME OF CEMETERY OR CREMATORY: Haneysville MethCem.
23d. LOCATION (City or Town) (County) (State): Bedford Co., Pa.
24. FUNERAL DIRECTOR: CONNER FUNERAL HOME ADDRESS: EVERETT, PA.
25a. RECD BY REGISTRAR DATE: APR 21 1969
25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 41
45M 1/69

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04803 — 04796

1. DECEASED NAME (Type or Print) First	Middle	Last
Marie	Elizabeth	Weaver

2a. DATE KNOWN OF DEATH ☒ / ESTIMATED ☐: Month, Day, Year: April 12, 19[illegible]
2b. HOUR: 2:37 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS: HOURS / MIN.
Female	White	3/ 1/1906	63 YRS		

2c. DATE PRONOUNCED DEAD: Month, Day, Year 19: April 13, 19[illegible]
2d. HOUR: 2:37 PM

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH
Maryland	U S A		Allegany Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Sacred Heart Hospital	Grocery Clerk-Retired	Hartman's Gr

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Allegany	Cumberland	YES ☐ NO ☒	Route 1, Bowman's Addition

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	Thomas		Margaret		Williams

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS
No	218-24-7929	Irvin Thomas, 16 Balto St. Cumberland, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS, RIGHT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 HRS
DUE TO, OR AS A CONSEQUENCE OF
(b): CORONARY SCLEROSIS — ---
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
22b. DATE SIGNED: APRIL 12, 19[illegible]
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/16/1969	Frostburg Memorial Park	Frostburg, Alleg Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
John J. Hefer, Jr. 230 Balto Ave. Cumberland Md.	APR 16 1969	[signature]

VR A15ME (5) 10M REV 1/68

1

04804

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04797

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 45M 1-68

1 DECEASED-NAME (Type or print) First: HENRY	Middle: Clay	Last: WHITE	2a DATE OF DEATH Month: 4 Day: 12 Year: 69	2b HOUR: 2:45 A.M.	
3. SEX: MALE	4 RACE: WHITE	5. DATE OF BIRTH: 8-5-1888	6 AGE (In years last birthday): 80 YRS	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a BIRTHPLACE (State or foreign country): W. VA.	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9 COUNTY OF DEATH: ALLEGANY		Md
10 CITY OR TOWN OF DEATH: CUMBERLAND	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Brewery		
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b COUNTY: ALLEGANY	13c CITY OR TOWN: CRESAPTOWN	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	13e STREET AND NUMBER: Valley View Dr. RT. #5, BOX 162	
14. FATHER'S NAME First: MADISON	Middle	Last: WHITE	15. MOTHER'S MAIDEN NAME First: ELIZABETH	Middle	Last: (WHITE)
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No.	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address: MEMORIAL HOSPITAL - CUMBERLAND, MD.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Renal failure
DUE TO, OR AS A CONSEQUENCE OF (b): far advanced metastatic carcinoma
DUE TO, OR AS A CONSEQUENCE OF (c): of prostate
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 yrs.

185X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED	20a AUTOPSY? YES [ ] NO [X]	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 4/8/69, to 4/12/69, that (I) (we) last saw the deceased alive on 4/11/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Walter N. Himmler M.D.	DEGREE	ATTENDING PHYS [X] MED DIRECTOR [ ] STAFF PHYS [ ]	22c DATE SIGNED: 4/14/69.
22d PHYSICIAN'S NAME (Type): DR. WALTER N. HIMMLER	22e ADDRESS: 412 N. MECHANIC ST., CUMBERLAND, MD		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE: 4/15/69	23c NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park,	23d LOCATION (City or Town): Cumberland,	(County): Allegany (State): Md.
24 FUNERAL DIRECTOR: H. Wayne George	ADDRESS: Cumberland, Maryland	25a. REC'D BY REGISTRAR DATE: APR 18 1969	25b. REGISTRAR'S SIGNATURE: Roberta Yonge	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4M
30M REV 1-68

04805

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

04798

1. DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b HOUR
Bessie		Whiteman	4 14 69	

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Female	White	12/10/1911	57 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9 COUNTY OF DEATH
Md	U.S.A.	WIDOWED ☒	Allegany Md.

10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Lonaconing (Rural)		House Work	Own Home

13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN (Rural)	13d INSIDE CITY LIMITS? YES / NO	13e. STREET AND NUMBER
Md	Allegany	Lonaconing	NO ☒	

14 FATHER'S NAME First	Middle	Last	15 MOTHER'S MAIDEN NAME First	Middle	Last
William		Goodwin	Hattie		Waxler

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no		Lloyd Whiteman Shaft, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ——

4109 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease — 2 years

DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Obesity - Schizophrenia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☐	

21a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from ——, 19 56 to April, 19 69, that (I) (we) last saw the deceased alive on April 7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b SIGNATURE	DEGREE	ATTENDING PHYS.	MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED
[signature]	MD	☒	☐	☐	4.15.69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
L.R. MILES, JR	LONACONING MD 21539

23a BURIAL CREMATION REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d LOCATION (City or Town) (County) (State)
Burial	4/17/69	Greens Cemetery	Garrett Md

24 FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
George Eichhorn	Lonaconing, Md.	APR 17 1969	[signature] Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04806

CERTIFICATE OF DEATH

04799

1 DECEASED NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b HOUR
ROSEMARY	E.	WILHELM	4	1	69	11:25 A.M.

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	8-9-1913	55 YRS		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MARYLAND	U. S. A.	MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	ALLEGANY Md

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
CUMBERLAND	MEMORIAL HOSPITAL	HOUSE WIFE	

13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MARYLAND	ALLEGANY	FROSTBURG, MD.	YES [ ] NO [ ]	124 WASHINGTON ST.,

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
EARL		PURBAUGH	TERESA		COLLINS

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
	214-07-2437	MEMORIAL HOSPITAL - CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Vascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO, OR AS A CONSEQUENCE OF (b) Marked arteriosclerosis — more

DUE TO, OR AS A CONSEQUENCE OF (c) pronounced ~~Cerebral~~ Cerebrally

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b)

Uremia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES [ ] NO [X]	

21a. ACCIDENT WAS UNDERLYING	21b. TIME OF INJURY	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
[ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	HOUR A.M. P.M. Month Day Year 19	

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I **certify** that (I) (this hospital) attended the deceased from 3-22-69, to 4-1-69, that (I) ~~(we)~~ last saw the deceased alive on 3-30-69 and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death

22b. SIGNATURE	DEGREE	ATTENDING PHYS	MED DIRECTOR	STAFF PHYS	22c. DATE SIGNED
Wm. F. Williams		[X]	[ ]	[ ]	4-3-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
DR. W. F. WILLIAMS	122 S. CENTRE ST., CUMBERLAND, MD.

23a. BURIAL, CREMATION REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	4-4-69	ST. MICHAEL'S CEMETERY	FROSTBURG, MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
JOSEPH R. DURST, FROSTBURG, MD. 21532	APR 7 1969	J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (3)
45M - 11/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04807

CERTIFICATE OF DEATH

04800

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Bertha,	M.	Wilkens	April 14 1969	4:47 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
female	White	11-21-97	71 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	U.S.A.		Allegany Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	12b. KIND OF BUSINESS OR INDUSTRY
Cumberland	Cumberland Nursing Centre	Clerking-Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Allegany	Cumberland	YES ☑ NO ☐	1303 Bedford Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Newton	M	Carder	Clara	E	O'Neil

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	214-05-6449	Mrs. Audrey Leasure - Cumb, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinomatosis, generalized — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Jan. 69

DUE TO, OR AS A CONSEQUENCE OF

(b) adeno-carcinoma stomach — Nov. 68?

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 151.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
1/17/69	Adenocarcinoma, cardia & lesser curvature, stomach.	YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, natify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. I certify that (I) (this hospital) attended the deceased from 8 November, 1968, to 14 apr., 1969, that (I) ~~(we)~~ last saw the deceased alive on 12 apr. 1969, and that in (my) (aur) apinion death occurred an the date and haur and from the causes stated abave, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED
W. A. Von Ormer, M.D					14 April 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
W. Alfred Van Ormer, M. D. Dr. Van Ormer M.D.	122 S. Centre Street, Cumberland, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	4/16/69	Hillcrest Burial Park	Cumberland Allegany Maryland

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Silcox-Merritt Funeral Service. Cumberland, Md 21502	APR 18 1969	Charles Judge

VR A15 (7) 30M REV. 1-68

1

04808

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

04801

CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: LONNIE	Middle: RAYMOND	Last: WINEBRENNER	2a. DATE OF DEATH Month: 4 Day: 23 Year: 69	2b. HOUR: 9:30 A.M. P.M.	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: 8-13-1898	6. AGE (In years last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U. S. A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: ALLEGANY Md.			
10. CITY OR TOWN OF DEATH: CUMBERLAND	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): CA Worker	12b. KIND OF BUSINESS OR INDUSTRY: Celanese Silk			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: ALLEGANY	13c. CITY OR TOWN: CUMBERLAND	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Wright's Lane BOWLING GREEN		
14. FATHER'S NAME First: WILLIAM	Middle: S.	Last: WINEBRENNER	15. MOTHER'S MAIDEN NAME First: SUSAN	Middle:	Last: Hutzel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No.	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 214-07-5834	17. INFORMANT: MEMORIAL HOSPITAL - CUMBERLAND, MD.	Address		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive heart failure

DUE TO, OR AS A CONSEQUENCE OF (b): Basic of Intraduced A. D. L. D. Dis.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4124

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: ?

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Emphysema; Pulmonary Fibrosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. I certify that (I) (this hospital) attended the deceased from 2-10-, 1969, to 4-23-, 1969, that (I) ~~(we)~~ last saw the deceased alive on 4-22-, 1969, and that in (my) ~~(our)~~ opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ ~~(did)~~ (did not) view the body after death.

22b. SIGNATURE: W. F. Williams	DEGREE	ATTENDING PHYS. [X]	MED. DIRECTOR [ ]	STAFF PHYS. [ ]	22c. DATE SIGNED: 4-24-69
22d. PHYSICIAN'S NAME (Type): DR. W. F. WILLIAMS	22e. ADDRESS: 122 S. CENTRE ST., CUMBERLAND, MD.				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 4/26/69	23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park,	23d. LOCATION (City or Town): Cumberland,	(County): Allegany (State): Md.
24. FUNERAL DIRECTOR: H. Wayne George	ADDRESS: Cumberland, Md.	25a. REC'D BY REGISTRAR DATE: APR 28 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

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45M - 1-69